Consultation with American Indians and Alaska Natives

A Report on the Continuing Dialogue Between the Department of Health and Human Services and American Indian and Alaska Native Leaders

January 2001

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

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Dear Tribal Leader:

We are pleased to present you with the enclosed report: "The Continuing Dialogue Between the Department of Health and Human Services and American Indian and Alaska Native Leaders."

On November 6, 2000, President Clinton reaffirmed the Administration's commitment to tribal sovereignty, self-determination, and self-government by issuing a revised Executive Order on Consultation and Coordination with Indian Tribal Governments. This is the latest in a series of directives regarding tribal consultation issued by the President since April, 1994, requiring each federal department and agency to establish a consultation policy.

As you know, the Department of Health and Human Services (HHS) quickly implemented the President's Executive Order and became the first federal department to issue a tribal consultation policy. Through the issuance and implementation of this policy, HHS has worked hard to be more responsive to the needs of American Indians and Alaska Natives. Over the course of the past several years, HHS leadership has provided numerous opportunities for tribal leaders to raise issues with the Department, such as at our regional listening councils, budget consultations, and National Tribal Consultation Forum. Most importantly, we have attempted to address those issues and to establish a relationship that will continue to thrive.

This report offers a look at some of the key efforts the Department has taken in furtherance of our consultation obligations and includes information that we hope will assist tribal leaders in your ongoing work with the Department. In particular, you will note that the report includes the Department's consultation plan, as well as the HHS agency-specific consultation plans. Although these consultation plans are "final," it is important to recognize that these are living documents that may evolve based on comments or recommendations you may make in the future. The report also systematically identifies the issues you have expressed at our many meetings.

We hope that the report offers a concrete agenda for action by the Department and tribal governments. Together, we can tackle the challenges necessary to bring health and opportunity to every American Indian and Alaska Native.

Sincerely,

Donna E. Shalala

Kevin Thurm

Enclosure

Acknowledgements

This volume is more than a description of the many meetings and conferences that the Department of Health and Human Services has held with tribal leaders and organizations. And it is more than a recitation of the important issues that American Indian and Alaska Natives have raised in the course of our consultations. More than anything else, it represents the Department's commitment to respect tribal sovereignty, self-determination, and self-government and to work with the tribes to bring health and prosperity to Indian country. Of course, the commitment on the part of the Department's leadership would come to naught without the encouragement, creativity, and energy of a large number of colleagues from throughout HHS and from our tribal partners.

We must recognize the tribal leaders whose direct input is reflected in this effort. We are grateful for the knowledge and experience these individuals have shared with us. We are especially thankful to David Gipp, Julia Davis, Ruey Darrow, Wanda Stone, Tim Martin, H. Sally Smith, Susan Masten, Buford Rolin, Merle Boyd, Jerry Freddie, Joe Saulque, Everette Enno, Helen Bonnaha, W. Ron Allen, Alvin Windy Boy, Sr., Henry Cagey, Yvette Joseph-Fox and Jack Jackson.

We also wish to thank the national tribal organizations that contributed their staff and other resources to the consultation process and provided invaluable advice and assistance. In particular, we extend our appreciation to the National Congress of American Indians, the National Indian Health Board, and the Tribal Self-Governance Advisory Committee to the Indian Health Service.

It is well known that one of the first steps the Department took to ensure that the highest level of attention was given to tribal consultation was to place responsibility over the process in the Office of Intergovernmental Affairs (IGA) and to establish in IGA a new position, that of Senior Advisor for Tribal Affairs. In December 2000, we were excited to announce the selection of Eugenia Tyner-Dawson. Prior to Gena, however, two individuals filled the position on an interim basis. First, Bea Bowman, on detail from IHS, joined the team.

Bea was instrumental in establishing the Department's consultation policy and its early implementation. In addition, working closely with the Deputy Secretary, she orchestrated the series of listening councils in 1998-1999. Following Bea's detail, Carol Martin, from IHS' Office of Tribal Self-Governance, joined IGA. Carol did an outstanding job overseeing the Department's budget consultation meetings and the July 2000 National Tribal Consultation Forum. In addition, Carol spearheaded the drafting of the interim report that preceded this volume. Bea and Carol brought to the position a strong knowledge of and commitment to the issues and, perhaps more than anything else, raised the bar regarding the skills and judgment that the person permanently filling the position would need to possess. Watching Eugenia Tyner-Dawson manage the completion and publication of this report, we know she will surpass expectations and serve IGA ably by bringing tribal issues to the forefront of the Department.

We are also greatly indebted to IHS' Verna Miller, who helped coordinate the Department's efforts in compiling the report, and Mirtha Beadle from the Office of the Executive Secretariat who brought structure to the report and helped navigate the document through the Department's clearance process.

We also give special thanks to the dedicated and committed staff from throughout the Department for their contributions to this report, as well as strengthening and implementing the Department's consultation policy: John Callahan, Michel Lincoln, Rae Snyder, Leo Nolan, Jim Mason, Kelley O'Dell, Lis Hanson, Steve Sawmelle, Linda Brown, Yvonne Jackson, Nick Burbank, Sharon McCully, Molly Varney, and Katie Smeltz.

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Executive Summary

Tribal governments and the U.S. Department of Health and Human Services (HHS or the Department) share the goal of eliminating the health disparities of American Indians and Alaska Natives (AI/ANs) and ensuring that their access to critical health and human services is maximized. To achieve this shared goal it is essential that tribes and the Department engage in open, continuous, and meaningful consultation. True consultation leads to information exchange, mutual understanding, and informed decision-making. The importance of consultations with tribal governments was affirmed through a Presidential Memorandum in 1994 and Executive Orders in 1997 and 2000.

Consistent with the President's directive 1994 Memorandum, HHS Secretary Donna E. Shalala issued a policy memorandum in 1997 entitled, "Department Policy on Consultation with American Indian/Alaska Native Tribes and Indian Organizations." With this memorandum, HHS became the first federal department to issue a tribal consultation policy to all its agencies. Since the issuance of the consultation policy, HHS has engaged in regional and national meetings with tribal leaders to discuss health and human services concerns of AI/ANs and budget priorities.

The purpose of this report is fourfold:

- to share the HHS tribal consultation policy, HHS agency consultation plans, and national consultation activities;
- to document national health and human services concerns and recommendations that were identified by tribal leaders at the five regional Listening Councils and the National Tribal Consultation Forum;
- to identify actions that HHS has taken and proposes to take to address issues that were identified by tribal leaders at the five regional Listening Councils and National Tribal Consultation Forum; and
- to establish a marker for future conversations and accountability.

Accordingly, this report provides background on HHS consultation activities over the past eight years and how these efforts have evolved into the Department's present relationship and consultations with tribal governments. A brief summary is provided on the six regional health forums that were held in 1995 and their relationship to the

succeeding five regional Listening Council meetings in 1998-1999 and the National Tribal Consultation Forum in 2000, HHS commitments to tribal leaders and accomplishments.

The first chapter, *Developing a Meaningful Tribal Consultation Policy*, describes consultation efforts to date and the directives that have guided and will guide Departmental consultation activities. The HHS Consultation plans are in Appendix 3.

Chapter Two, *Listening Councils*, provides information about the regional Listening Councils held in Arizona, North Dakota, Washington, Oklahoma, and New York during 1998 and 1999. Deputy Secretary Kevin Thurm participated in these meetings with Indian Health Service Director, Dr. Michael Trujillo, and approximately 250 representatives of tribal governments and other Indian organizations, including urban Indian health providers.

The major themes and national issues, as well as the local or regional issues, which emerged at the regional Listening Councils are described. Fifty-two (52) distinct issues were identified and divided into seven major themes: Funding and Budget Issues; Services and Service Provision; Care Providers; Facilities, Equipment, and Supplies; Intergovernmental Relations and Related Issues; Infrastructure; and Data and Research.

Chapter Three, *National Tribal Consultation Forum*, describes the National Tribal Consultation Forum (NTCF) which the Department hosted in July, 2000 to provide feedback on the issues raised at the regional Listening Councils and to address additional concerns. The feedback to tribes from HHS agencies and dialogue at the NTCF opened the doors to more meaningful discussions.

Chapter Four, *Next Steps*, describes actions that HHS and Tribes (individually and together) should take to maintain the momentum and ensure continuous progress.

This report includes a number of Appendices that provide useful information, including HHS agency consultation plans and a matrix that summarizes the responses from HHS agencies to issues and recommendations raised by tribal and urban Indian leaders at regional and national meetings. Each issue/issue area identifies: public laws or related authorization, proposed action, activities to date, related appropriations information, obstacles, strategies to overcome obstacles, and HHS contacts. Responses from the agencies offer the beginning of the ongoing dialogue between the federal government and tribes regarding overall health and human service issues.

Chapter I

Developing a Meaningful Tribal Consultation Policy

Consultation is an enhanced form of communication that emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, that leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making.

–Secretary Donna E. Shalala

HHS' efforts to establish a meaningful tribal consultation policy - one that is institutionalized throughout the Department and a part of its decision-making process - stem from President Clinton's April 1994 Memorandum to the heads of executive departments and agencies entitled, "Government-to-Government Relations with Native American Tribal Governments." The Memorandum reaffirms the unique and firmly established legal relationship that has long existed between tribal governments and the federal government, affirmed in treaties, the U.S. Constitution, federal statutes, court decisions, Executive Branch policies, as well as in moral and ethical considerations. It goes on "to clarify our responsibility to ensure that the Federal Government operates within a government-to-government relationship with federally recognized Native American tribes" and to direct each federal department and agency to honor this relationship by consulting to the greatest extent practicable and to the extent permitted by law with tribal governments prior to taking actions that will affect [them]."

Consequently, the White House Domestic Policy Council (DPC) convened an interagency working group, chaired by the Secretary of the Interior, which requested that each Department develop its own operational definition of "consultation" with American Indian and Alaska Native Tribes. The working group determined that a uniform Administration-wide policy was not desirable, given the different organizational structures, statutory considerations, and administrative processes among federal departments and agencies.

At the same time, Dr. Phillip Lee, then HHS' Assistant Secretary for Health, and Dr. Michael Trujillo, Director, Indian Health Service (IHS), held a series of regional meetings with tribal leaders on national health care reform and on the health care reforms being initiated by state governments. Those meetings provided an unprecedented opportunity to bring together tribal leaders, urban Indian programs, state government representatives, and officials from HHS' Health Care Financing Administration, Indian Health Service, Office for Civil Rights, and the Department of Interior's Bureau of Indian Affairs to discuss health care reform issues common to the Tribes. In all, six regional forums were held across the country in 1995.

Following up on the Lee-Trujillo meetings and based on the findings of the DPC working group, Secretary Shalala in August 1997 formally established the Department's tribal consultation policy in a memorandum entitled, "Department Policy on Consultation with American Indian/Alaska Native Tribes and Indian Organizations." In it the Secretary endorsed the Department-wide consultation plan, which was developed by the HHS Working Group on Consultations with American Indians and Alaska Natives, and further directed all HHS operating divisions to draft agency-specific plans that would be based on the Department's definition of consultation.

In addition, the Secretary recommended that the Department:

1. Consult with Indian people to the greatest practicable extent and to the extent permitted by law before taking actions that affect these governments and people;

2. Assist states in the development and implementation of mechanisms for consultation with their respective tribal governments and Indian organizations before taking actions that affect these governments and/or the Indian people residing within their state. Consultation should be conducted in a meaningful manner that is consistent with the definition of "consultation" as defined in this policy including reporting to the appropriate HHS agency on its findings, and on the results of the consultation process that was utilized;

3. Assess the impact of this Department's plans, projects, programs and activities on tribal and other available resources;

4. Remove any procedural impediments to working directly with tribal governments or Indian people; and

5. Work collaboratively with other federal agencies in these efforts.

In that same memorandum, the Secretary placed overall responsibility for managing the Department's consultation obligations in the Office of Intergovernmental Affairs (IGA), an important step, given that IGA is the focal point in the Office of the Secretary for the Department's communications with states and local governments. Among its other responsibilities, IGA would serve as a "single point-of-contact that can provide AI/AN representatives with access to Departmental program information and assistance."

In addition, the Secretary directed each HHS agency to draft tribal consultation plans that would be based on the principles stated above, but also would consider the unique missions and structures of each agency. HHS agencies, following tribal consultations, have written and finalized their tribal consultation plans. Although these plans are in final form and are being implemented by the respective agencies, they are "living" documents that may be revised as necessary. The HHS consultation plans can be found in Appendix 3 of this report.

As a first major step in fulfilling the Department's consultation obligations, Deputy Secretary Kevin Thurm and IHS Director Michael Trujillo, M.D. held five regional Listening Councils with tribal leaders in 1998 and 1999. Representatives of Indian organizations and urban Indian health providers were also in attendance. At the Listening Councils, tribal leaders were invited to raise issues and concerns related to HHS policies and programs. In sum, the Listening Councils' aim was to obtain tribal leaders' input on this question:

What do we need to do together, the federal government and tribal governments, to help bring the promise of health, well being and opportunity to American Indians and Alaska Natives?

At the National Tribal Consultation Forum held in Washington, D.C. on July 19-20, 2000, HHS responded to this question as well as to the individual issues raised at the Listening Councils. Although some questions remain unanswered, the Department is committed to continuing the dialogue with tribal leaders and providing additional feedback. Indeed, one objective of this report is to ensure that the Department and tribal leaders keep track of the numerous issues that have been raised at our consultation meetings and avoid having to begin anew at future meetings.

Another important step the Department has taken, in accordance with its consultation policy, has been the holding of its annual tribal budget consultation meeting chaired by the Assistant Secretary for Management and Budget (ASMB). Held first in May 1999 and again in April 2000, ASMB convened these meetings before the Department's agencies submitted their annual appropriations requests to the Secretary.

The impact of the Department consultations with tribal leaders and, in particular, the budget consultations, has been reflected in the Department's annual budgets and its policies. For example, since 1995, the IHS budget has increased 41 percent, leading to more clinical services, more mental health services, more dental visits, and more health care for elders on reservations. In FY 2001, the Centers for Disease Control and Prevention and the National Institutes of Health will invest $615 million in diabetes research and prevention. In 1999, the Health Care Financing Administration announced that it would exempt American Indian and Alaskan Native children from cost sharing under the State Child Health Insurance Program (SCHIP), thereby removing a significant barrier in enrollment.

The Administration's and the Department's tribal consultation polices will and must evolve as the needs of the tribes and the government-to-government relationship changes. The most recent development was President Clinton's issuance on November 6, 2000 of Executive Order 13175 entitled, "Consultation and Coordination with Indian Tribal Governments." In releasing the Executive Order, President Clinton stated:

Today, there is nothing more important in federal-tribal relations than fostering true government-to-government relations to empower American Indians and Alaska Natives to improve their own lives, the lives of their children, and the generations to come. We must continue to engage in a partnership, so that the First Americans can reach their full potential. So, in our nation's relations with Indian tribes, our first principle must be to respect the right of American Indians and Alaska Natives to self-determination.

Under the leadership of Secretary Shalala and Deputy Secretary Kevin Thurm, HHS has worked hard to comply with both the letter and the spirit of these words. Nonetheless, as suggested in chapters II and III of this volume, having engaged in an intense dialogue with our tribal partners, we know that many issues remain unresolved and many needs unmet.

Chapter II–Listening Councils

A Description of the Listening Councils

Scottsdale, Arizona, October 14, 1998

The Scottsdale Listening Council, was moderated by Anthony Largo, spokesperson for the Santa Rosa Band of Cahuilla Indians in California, and included approximately 32 tribal leaders and other tribal representatives from Southern California, Arizona, Nevada, Utah, Colorado and New Mexico. The meeting began with introductions by each tribal leader and Dr. Trujillo and Deputy Secretary Thurm. Time was provided for tribal leaders wishing to make a statement, first on matters related to health, then on matters related to human services. A significant portion of the discussion focused on the consultation process and how to make it more effective and meaningful with wanting to confirm the steps involved in meaningful consultation and the feedback that they could expect from these Listening Councils. Forty-three individual issues and recommendations were identified during the Scottsdale meeting, most of which were "crosscutting" or national in focus.

Regional/Local Issues: The decrease in Medi-Cal reimbursements in California and the gap in funding it created for tribal and urban Indian health care providers. The allocation of new funds under the IHS Diabetes Initiative, specifically that California Tribes may be receiving an inequitable distribution. The funding needed to replace the Phoenix Indian Medical Center in Phoenix, Arizona (this facility has been on the IHS facility construction priority list). The need for funding to replace the Fort Defiance Indian Hospital on the Navajo Reservation, and the need for a hospital facility to serve the Tribes in Nevada, who are located too far away from the Phoenix Indian Medical Center to access that facility. The need was expressed for facility construction funding for California Tribes and concerns regarding multigenerational exposure to uranium mining and its related hazardous effects.

Crosscutting Issues: The participants raised concerns about the HHS consultation process and, in particular, the Administration's commitment to the process. It was recommended that the Secretary establish an "Indian Desk" in the Office of the Secretary. Strong support was voiced for the existing IHS budget formulation and the manner in which it involves tribal consultation throughout. Participants recommended that the self-governance process be made permanent for the IHS, and that contract support cost funding not be allocated on a pro rata basis. It was also recommended that HHS apply the provisions of the Indian Self-Determination and Education Assistance Act (P.L. 93-638), contracting of programs, to all agencies within the Department, not only the IHS.

Concerns were raised about the amount of funding for all IHS programs and services and the process through which funding the IHS allocates, and the lack of support for home- and community-based care for patients with disabilities. The distribution of resources within the IHS system was another concern, and the need to focus more funding and services on alcoholism and substance abuse, the elderly, youth, accident prevention, emergency medical services, complications from chronic diseases, such as diabetes, and the recruitment and retention of qualified Indian health professionals. Concerns were raised about the inadequacy of facilities and infrastructure and, specifically, the need for new or refurbished outpatient and inpatient facilities and sanitary water and updated sewer systems for Indian communities. The Tribal leaders raised the difficulties experienced with reimbursement for services available through Medicare and Medicaid; the need for technical assistance to enable them to more effectively secure reimbursement for eligible patients; assistance in coordinating with state managed care systems and improving third party billing. Additionally, concern was expressed about the impact of the new welfare reform system, Temporary Assistance to Needy Families (TANF) on tribal members. Finally, participants voiced strong concern that the federal government needs to do more to fulfill its trust responsibility by providing the quality and quantity of health care needed by tribes.

Bismarck, North Dakota, December 4, 1998

The Bismarck Listening Council included tribal leaders from Montana, Wyoming, North Dakota, South Dakota, Minnesota, Wisconsin and Iowa. Dr. David Gipp, President of the United Tribes Technical College, served as the moderator for this meeting. Approximately 35 individuals made presentations at the Bismarck meeting.

Regional/Local Issues: Several participants stated that Treaty Tribes were not receiving an equitable distribution of IHS resources and that health status indicators, which reflect severe health problems among the Northern Plains Tribes, such as infant mortality, are not adequately incorporated into allocation decisions. Tribal leaders expressed a fear that the IHS would be required to "means-test" to determine financial eligibility for services at some point in the future. They raised the issue of increasing reliance of the IHS upon revenues from Medicare and Medicaid underscored their concerns about means testing. The leaders questioned the validity of the IHS as a "residual" provider of health care and recommended that it be the "primary" provider of health services for Indian people and be funded appropriately. Tribal leaders recommended that tribes be "treated as states" in determining eligibility for other federal programs and resources beyond the IHS. It was suggested that HHS resources be combined into "block grants" and funded directly to tribal governments. Tribal leaders

expressed concern about the social and financial impact of Indian families returning from urban areas to live on the reservations. Other regional concerns included the lack of adequate funding for the "Healthy Start" program, overall funding for children's health and the need to develop treatment programs for those using methamphetamine. It was recommended that the IHS conduct a national strategic planning process to better respond to the changing environment and that it consider "regional advocacy" to better focus on the unique health needs in each region.

Crosscutting Issues: Participants focused much of the discussion on the consultation process and the commitment of HHS to follow-up and respond to tribal issues and recommendations. The lack of funding for all aspects of the IHS was highlighted specifically for Contract Health Services (CHS), alcohol prevention, adolescent health, elderly care, nursing home care, diabetes, cancer, the Catastrophic Health Emergency Fund (CHEF), emergency medical services, HIV/AIDS, mental health services and appropriate staffing of health professionals. Like other regions, Bismarck participants were concerned about the lack of funding for new and replacement hospitals and clinics. The issue of traditional Indian healing practices and its relationship to the IHS was also raised.

Other issues included Racism or "anti-Indian sentiment" surrounding Indian reservations and communities. Technical assistance was needed in dealing with states regarding managed care and other reimbursement issues. It was recommended that federal law be amended to make Indian health care an "entitlement" as opposed to a discretionary program of the government. HHS was asked to support the reauthorization of the Indian Health Care Improvement Act (P.L. 94-437). Concern was raised that the current Medicare program does not adequately support costs associated with nursing home care, including questions regarding eligibility for IHS services and requests that a final rule be established. The impact that depressed reservation economies have on the health status of Indian families should be addressed more holistically. The United States Department of Agriculture Commodity Food Program was identified as one of the problems in making a connection between improved health care and addressing the effects of poverty. The impact of welfare reform on Indian families and their health care was identified as well as environmental issues affecting Indian health status, such as water pollution, bad roads, and lack of transportation services. Finally, participants asked that Congress make a long-term commitment to Indian people and fully fund its treaty obligations to provide health services.

Seattle, Washington, January 21, 1999

The Seattle Listening Council included tribal leaders from Alaska, Washington, Oregon, Idaho and Northern California and was moderated by Julia Davis, a member of the Nez Perce Tribal Executive Committee. Approximately 56 individuals participated in this Listening Council. Each elected tribal official was provided time to make a formal statement or present an issue to the federal representatives.

Regional/Local Issues: Participants raised concerns for the increase in inhalant abuse among Indian youth and the need for treatment services for this population. A recommendation was made that existing federal law be modified so that individual tribes can access funds appropriated for Regional Youth Treatment Centers (RYTC) to address substance abuse issues locally. California tribal leaders recommended that at least two RYTC be allowed in that State to cover the vast territory. A separate recommendation was made to support the operation of the existing RYTC.

Tribal leaders asked for technical assistance to access federal tobacco control funding; increased funds to serve the large number of urban Indians in California. Participants requested that the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) assist tribes in the development of local Institutional Research Boards (IRB) and provide tribes with the opportunity to approve and review any and all research affecting tribes. The need was expressed to appoint Indian people to the Medicare and Medicaid Advisory Committee through HHS and to require that the Health Resources and Services Administration (HRSA) go through a similar consultation process with tribes. Concerns about the Base Closure Act and whether tribal interests were protected and included in this process was also discussed.

Crosscutting Issues: Participants discussed the HHS consultation process and the steps for follow-up to the Listening Councils. The federal obligation to fulfill Indian treaty rights, its trust responsibility to provide health services, and the requirement that Congress appropriate adequate funds to meet this obligation, was a cornerstone of these discussions. The concern was expressed that funding is not adequate across the board for IHS, in particular full funding for "mandatory increases," such as medical inflation, payroll increases and population growth should not be taken away from service funds but funded additionally. Increased funding is needed for diabetes, Contract Health Services (CHS), dental care, catastrophic illnesses and accidents, elderly care, adolescent health, alcohol and substance abuse treatment and prevention and staffing.

The lack of funding for facilities construction for outpatient clinics and sanitary water/sewer systems was also identified. The "Joint Venture" program to fund the equipment and staffing of tribally constructed outpatient health clinics was identified as a successful model and recommended to receive more attention and future funding.

Tribal representatives identified the problem of patient travel and geographical access barriers to care and transportation costs as hindering their ability to provide adequate services. Tribal leaders also voiced strong support for the elevation of the Director of the IHS to an Assistant Secretary level. Participants voiced their support for the reauthorization of the IHCIA and asked for assistance and

advocacy from the Health Care Financing Administration (HCFA) in educating states about the unique status of tribes. The current Memorandum of Agreement between the IHS and HCFA needs more exposure at the state level and barriers to Medicare/Medicaid reimbursement for tribes must be addressed. Questions were raised about the unwillingness of some states to reimburse tribes retroactively as "Federally Qualified Health Centers" (FQHC), under the IHS/HCFA Memorandum of Agreement. It was recommended that HCFA engage in negotiated rulemaking and meaningful consultation with tribal governments on these and other issues. The tribal leaders voiced strong support that IHS services should be funded as an entitlement; not on a discretionary basis. The issue of "equity" in the allocation of IHS resources was raised, and a recommendation was made that an actuarial approach be adopted in the allocation of funds.

With regard to welfare reform, participants voiced concern that a formal tribal consultation process be initiated for TANF issues. It was recommended that federal support be provided to administer TANF funds for tribes, just as it is provided for states. Questions were raised about the process and funding allocation methodology under the child support enforcement statute and the need for more attention on this issue. More funding is needed for social service programs in tribal communities. Child welfare funds should go directly to tribes and not through states. The ceiling on indirect cost rates allowable to tribal Head Start programs is a problem and should be lifted.

Oklahoma City, Oklahoma, March 9, 1999

The Oklahoma City Listening Council included 104 tribal leaders and Indian organization representatives from Oklahoma, Kansas, Nebraska and Texas. The meeting was facilitated by Ruey Darrow, Chairman of the Fort Sill Apache Tribe in Oklahoma and Wanda Stone, Chairperson for the Kaw Tribe of Oklahoma. Dr. Trujillo provided an overview and expressed HHS's intent to "bring into effect the consultation process" and involvement of tribes with the numerous agencies and programs of the Department. While HHS has an Indian-specific agency and program, (IHS and the Administration for Native Americans (ANA)), there are many more programs and authorities under the Department that impact tribal communities and should be addressed. Deputy Secretary Thurm made a brief presentation regarding his intent to listen to the concerns voiced by tribes and his commitment to provide feedback and follow-up on the major themes that emerge. He also stated that it was his goal to institutionalize this consultation process within HHS, so that it will not be dependent on any one individual but will be an ongoing departmental process.

Regional/Local Issues: A recurring regional j19 theme that emerged at the Oklahoma City Listening Council as well was the issue of "equity" in the distribution the IHS resources and the belief that Oklahoma was not receiving its fair share based upon a per capita allocation formula. While strong support was voiced for overall increases to the IHS budget, the allocation methodology within the IHS was identified as requiring more attention and fairness. Support was voiced for construction funding for replacement of the Lawton Indian Hospital and for increased funding for maintenance and improvement at that facility. Increased funding at all the Oklahoma Area hospitals was recommended.

A question was raised regarding the potential impacts of planned contracting of the Claremore Hospital under the Indian Self-Determination and Education Assistance Act (P.L. 93-638). It was recommended that additional funds be provided to support a needed inpatient alcohol and drug treatment facility in Western Oklahoma. There were conflicting recommendations expressed regarding the two urban demonstration projects funded in Oklahoma City and Tulsa, with participants suggesting that these programs be made permanent under P.L. 94-437 and others suggesting that only Tulsa should be designated permanent status. A recommendation was also made to extend coverage under the Federal Tort Claims Act and the Office of Management and Budget (OMB) reimbursement rates for Medicare and Medicaid to these two urban demonstration sites.

Crosscutting Issues: A majority of the issues discussed at the Oklahoma City Listening Council were of national and crosscutting significance. Increased funding for existing IHS initiatives was a recurring theme. Tribal leaders also recommended that the IHS develop a system whereby any IHS eligible patient can receive service at any IHS funded facility and that facility will be reimbursed by that patient's tribal or IHS provider. More funds are needed for diabetes, Community Health Representatives (CHR), environmental health, emergency medical services, pharmacy services, elderly care, dialysis, health scholarships, alcohol and substance abuse treatment and prevention, public health nursing, community health training, and increased funding for dental services.

Like other regions, the tribal leaders at the Oklahoma City meeting expressed their concern that funding is not adequate for the construction of new and replacement inpatient and outpatient facilities. Recommendations were made to lift the moratorium on contracting under P.L. 93-638 and to adequately fund Contract Support Costs and Indirect Costs. Tribal participants asked for a consultation process with HCFA to improve third-party billing for tribes. Reimbursement rates for tribes and urban programs under FQHC are scheduled to decline to only 70% of costs with no plan to cover that gap. It was recommended that the "direct billing" for Medicaid and Medicare be approved for all tribes contracting their own health systems, and not just the tribes participating in a demonstration project. Tribal representatives requested help from HHS to get Medicare coverage for home health care and hospice care for their elderly. Tribal leaders

asked that the HHS Secretary use her authority to waive the budget "caps" for the IHS when preparing the annual budget request. As in other regions, the problem of access due to inadequate transportation services was highlighted.

Other issues included: Support for the elevation of the IHS Director to an Assistant Secretary level. Lift the moratorium on defining eligibility regulations for HIS. Establish an Indian Advisory Committee at HHS. Concern was expressed about welfare reform implementation and whether it can work in the face of high unemployment in Indian country. Concern was expressed regarding funding cuts to the Child Care Bureau; funding needed for construction of Head Start facilities, and access to increased funding and support from other HHS agencies such as NIH and CDC.

Syracuse, New York, May 21, 1999

The Syracuse Listening Council was a forum for Eastern and Southeastern Tribes located in New York, Maine, Massachusetts, Rhode Island, Connecticut, North Carolina, South Carolina, Mississippi, Alabama, Louisiana, and Florida. Mr. Tim Martin, Executive Director of the United South and Eastern Tribes (USET) moderated the meeting.

Regional/Local Issues: The international border between the United States and Canada creates many difficulties for tribal programs serving families with ties to both countries. Specifically, tribal leaders expressed frustration about the difficulty in making child custody placements or child custody agreements when each parent resides on a different side of the border. They sought HHS assistance in enlisting the support of the State Department. A concern was raised that the public as well as the state and federal governments have a false perception of the availability of "gaming revenue" to meet tribes' health and human services needs. Many tribes do not operate gaming enterprises, and most of those that do operate such facilities do not generate the level of funding necessary to meet the significant health and human service needs in tribal communities.

There were concerns about the rise in the number of AI/ANs who smoke and in heart disease due to the lack of adequate prevention initiatives. They expressed the need for more radiology and optometry services, and an increase in substance abuse. Tribal representatives identified the Department of Justice "Drug Courts" as an excellent model of integrating health and law enforcement resources to intervene with addicted individuals. The participants identified a need for more flexibility in HHS programs. Tribal leaders also discussed the concern about Indian burial sites being disturbed and vandalized.

Crosscutting Issues: Tribal leaders were particularly concerned about the specific steps that the HHS would take to document, investigate and respond to each issue and recommendation raised.

Participants expressed the need for "aftercare" services for Indian patients coming home from inpatient alcohol and drug treatment. There is a significant amount of air and water pollution in the northeastern states which adversely impact the health of Indian communities. While this was expressed as a regional issue, it was also a common concern in other areas.

Additional funding for Indian health services was a recurring theme. Tribal leaders recommended a structured HCFA consultation process through which issues relating to Medicaid and Medicare reimbursement rates could be addressed. Participants also requested a standard federal rate for hospital services, similar to the standard Medicare rate, which limits the amount hospitals can charge for services to Medicare patients. Tribes expressed concern that states are not recognizing, cooperating with or serving Indian communities. Participants expressed concern about the allocation of IHS resources and recommended that the "Level of Need Funding" (LNF) formula be reviewed for fairness and improvement. It was also recommended that the overall impact on funding due to contracting and compacting under P.L. 93-638, be reviewed.

The Tribal leaders voiced support for the elevation of the IHS Director to an Assistant Secretary level. Concern was expressed about the lack of adequate data systems to report and monitor the health status of Indian populations. Services provided with IHS dollars to "non-eligible" populations should require additional funds. When the federal government recognizes new tribes, additional funds should be appropriated to support the health needs of that tribe rather than taking it from the existing IHS budget. Tribal leaders expressed their support for the reauthorization of the IHCIA and recommended that Indian health care be made an "entitlement," not a discretionary program.

Other issues included: TANF implementation and the need for more resources for child care services in Indian communities as well as HHS flexibility with respect to program requirements when dealing with tribal governments. Participants identified the need to provide social services to families returning from other areas to their home reservations. They also expressed their desire for the protection of tribal languages and tribal cultures. Tribal leaders expressed the concern regarding the inadequacy of IHS funding to meet Indian health needs, in particular for diabetes, alcohol and substance abuse, CHS, prevention initiatives, long-term elder care, tobacco control and smoking cessation, cancer and heart disease prevention and treatment, HIV/AIDS, dental care, radiology, optometry, youth education, and construction of tribal health facilities. The need for scholarship assistance to Indian students interested in health professions was also a concern.

In honoring its treaty obligations, included the obligation to provide health services, Tribal leaders emphasized that the federal government, in particular the Office of Management and Budget (OMB), must consult with tribes in making decisions that affect tribal communities.

B. Summary of Crosscutting Issues and Themes that Emerged

In all, tribal leaders and other Indian organization representatives raised 52 distinct crosscutting or national issues and recommendations at the five Listening Councils which are divided into seven categories or themes as follows:

1. Funding and Budget Issues
2. Services and Service Provision
3. Care Providers
4. Facilities, Equipment and Supplies
5. Intergovernmental Relations and Related Issues
6. Infrastructure
7. Data and Research

The majority of individual issues and recommendations raised by tribal leaders (20 out of 52) related to the first category, "Funding and Budget Issues." The next most frequently addressed area (14) was "Intergovernmental Relations and Related Issues." The category "Services and Service Provision" included 8 distinct issues. The remaining categories had fewer than 5 distinct issues in each. The following is a brief discussion of each of the seven major themes.

1. Funding and Budget Issues

This category consolidates a wide array of concerns expressed by tribal leaders, ranging from appropriations for specific IHS programs to reimbursement policies of the Medicaid and Medicare programs. Many of the concerns relate directly to the level of funds appropriated to the IHS to support health services, transportation, sanitation services, construction, CHRs, and nursing. Other issues and concerns relate to policies within the IHS, such as the distribution and allocation of resources among the tribes and areas within the IHS system. Other issues relate to legislative mandates by the Congress, such as the moratorium on contracting under the P.L. 93-638 and related funding for contract support costs. Concerns were also raised regarding the eligibility for services address both IHS policy and congressional mandates. A summary of the funding/budget issues and recommendations is as follows:

Health Services and Transportation: Funding is insufficient for health services and transportation services. Establish a line item for health services. Support appropriation for health services at level of need.

Water and Sewer Systems: Funding is lacking for water and sewer maintenance and repairs and testing of water systems. Appropriately fund maintenance and improvements.

Construction Financing: Funding is lacking to build, expand, replace, and maintain health care facilities. Find innovative financing for tribes to build health care facilities.

Native Healers: Funding is lacking for traditional native healers and practitioners.

Prevention: Funding is lacking for prevention activities. Funding is only enough to address primary care.

CHR/CHN: Community Health Representatives and Clinical Health Nurse Programs are underfunded.

CHS: Contract Health Services are underfunded. Earmark funds for CHS and increase CHS funds.

Targeted Health Needs: Environmental health; Emergency Medical Services (EMS); long-term elderly care; aftercare services; alcohol/substance abuse programs; diabetes programs; prevention, intervention and health education programs and outreach efforts are all underfunded. Appropriate line items for EMS funds, tribal EMS programs, elder care, alcohol prevention and treatment and commit to long-term diabetes initiative.

Contract Support Costs: Administrative and indirect funds for compacting and contracting under P.L. 93-638 are underfunded. Appropriate sufficient funds for administrative costs to tribes.

Equity within IHS: Appropriations are insufficient to keep pace with inflation, growth of Indian population or level of needs. There is inequitable funding for tribes and Areas on per capita allocation.

Inadequate allocation formula: Amend the IHCIA section that authorizes the IHS improvement fund to provide for equity funding.

P.L. 93-638 Contracting: Opposition to moratorium on P.L. 93-638 funding, payment of Contract Support Costs or reallocation of CSC on a pro rata method.

Equity Compared to Other Populations: Funding for Indian population as compared to other U.S. populations is inequitable. Fully involve tribes in the budget process and budget discussions and legislation.

Third Party Revenues: There is inappropriate consideration of third-party collections in budget decisions.

Managed Care: Assess the impact of managed care on tribes and tribal reimbursements.

Demonstration Projects: Provide more funds for demonstration grants on important health issues. It is difficult to implement new approaches to care without adequate or accessible funding.

Service Eligibility and Payment: Services provided to other tribes' members limits or reduces funds to tribes providing the service.

HCFA, Medicaid and Managed Care: Assist tribes in working with HCFA in the area of managed care.

IHS Capitated Restrictions: Support a provision that authorizes IHS to enter into capitation agreements for managed care.

Medicare: Assist freestanding health centers in billing Medicare for outpatient services.

Diabetes Fund Allocation: Change the allocation methodology for diabetes funding.

2. Services and Service Provision

The next major crosscutting theme incorporates issues related to the provision of services.

Traditional Healers: Recognize and support the need and use of traditional American Indian healers. There should be a policy that recognizes the use of traditional American Indian healers and practitioners in mental health.

Expand scope of services provided: Need to improve and provide access to: specialty and inpatient care, behavioral health services, including alcohol/substance abuse programs that include services for children, adolescents and women; diabetes programs; prevention and health education; pre-hospital emergency medical services; hospice and physical therapy programs; long term elderly care; and in home or special transportation for disabled people. IHS should be given authority to license long-term health care units on reservations. Support is needed in obtaining ambulances to provide 24-hour coverage.

Dialysis units: There is a need for dialysis units and to increase the size of existing units.

Access to alternatives: Access to "charity care" is lacking.

Cancer Screening: Increase focus on cancer screening for men.

Holistic Services: Provide holistic services for families, including mental health services.

Medicaid Barriers: Need to address barriers for parents who are not legally married and are unable to enroll their families in Medicaid.

Medicare and Medicaid Outreach: Outreach is needed to develop brochure describing Medicare benefits and provide information on Medicare and Medicaid in plain language.

3. Care Providers

The third crosscutting theme involved improvements or increasing the numbers and types of care providers available to Indian communities. The IHS has available to it programs under Title I of P.L. 94-437 to recruit, train, place and retain qualified health professionals. Despite this resource, tribes voiced concern about the lack of providers in certain fields and the difficulty in retaining providers.

More Providers of Care Needed: Too few health care providers result in high patient care load. IHS must use existing options to encourage careers in IHS and enhance training of American Indians/Alaska Natives (AI/AN) in health professions.

Provider Licensure: Some providers lack appropriate credentials. Assist tribes with licensing of dentists and doctors who are licensed in another state. Assist tribes to access training and continuing education for physicians and staff.

4. Facilities, Equipment and Supplies:

The fourth theme included issues and recommendations regarding facilities, tribal leaders at all five Listening Councils raised equipment and supplies. Many tribes expressed support for their local inpatient or outpatient facility to be replaced or newly constructed. Others expressed concern about the lack of funding for basic upkeep of existing facilities.

Lack of Facilities: There is a lack of facilities for health services, chemical dependency programs, renal dialysis units/clinics, nursing homes, and emergency rooms. Assist tribes to find alternate means for constructing needed facilities and upgrade emergency rooms.

Quality of Facilities: Facilities are unable to meet Joint Commission for the Accreditation of Health Care Organizations (JCAHCO) standards which means tribal facilities cannot compete with non-tribal facilities for patients.

Facility Construction/Replacement Process: The existing IHS process to identify, prioritize and justify new construction and replacement is time consuming and not working. Facility construction issues affect the number of medical staff, equipment, supplies and auxiliary providers. Delay in new construction also delays funding to bridge the gap between existing services and required services.

Equipment: A need exists for disaster preparedness and disaster response equipment.

5. Intergovernmental Relations and Related Issues:

One theme focused upon at all of the five Listening Councils was the area of tribal consultation, follow-up, and intergovernmental relations. The legal and historic government-to-government relationship is the foundation for these tribal consultation meetings and must not be overlooked. Beyond the process of holding meetings, tribal leaders want assurance that specific follow-up would be undertaken by HHS to address each of the issues raised and institutionalize the consultation process. There were fourteen specific issue areas, and recommendations, identified under this major theme.

Partnerships: Explore new and creative approaches or partnerships for efficient delivery of services for tribes. Encourage collaboration between state and tribal governments. Assist in helping private businesses become partners with tribes.

Input and Advocacy: Establish a HHS Advisory body that includes tribal leaders. Develop a website for AI/AN to make their needs known or respond to issues that affect them. Assure that all tribes are Internet capable. Establish an "Indian Desk" in all HHS agencies to allow better access to resources and technical assistance.

Consultation Follow-Up: Tribal leaders expressed their concern about another consultation process without clear follow up. Establish a plan and timeline for achieving results to the Listening Council meetings.

State Relations: States do not have adequate outreach services in rural areas of the states.

Direct Federal Funding: Tribes need to have access to more than just demonstration projects. HHS should implement a pilot program for direct federal funding to tribes from agencies rather than going through the states. Look beyond the IHS for funding to identify other sources that should be made available to tribes. Initiate and develop tribal specific grants.

Welfare Reform: Address the impact of welfare reform on AI/AN.

Budget Formulation: Provide tribes the opportunity to impact the long term planning for the budget. The budget consultation discussion centers on forgone conclusions, loss of opportunity to influence the outcome. HHS should allow for joint funding of projects to fund services more comprehensively.

Remove Caps on Indirect Rates: Tribes are seeking to raise the cap on funding of indirect costs allowed for Head Start programs which they administer.

Technical Assistance and Information: Assist tribes to maneuver through the federal system by providing contacts in each agency for technical assistance and information dissemination. There are too many obstacles and red tape.

International Border Issues: The international border issues, such as the U.S. and Canada, create many difficulties for tribal programs serving Indian people with ties to both countries. For example, tribes are not able to provide services for children of divorced parents when one parent resides in the U.S. and the other resides outside the U.S.

Consultation Overload: The agency-level consultation process places a burden on tribes. There should be one workable consultation process.

HHS Key Staff: Fill the permanent positions in the Office of the Secretary, Office of Intergovernmental Affairs.

IHS Director Elevation: Elevate the position of IHS Director to Assistant Secretary.

6. Infrastructure

The deterioration of sanitary water and sewer infrastructure systems was identified at several of the Listening Councils. Tribes have requested assistance to repair these systems and adequately fund operations and maintenance. Training should be provided to tribes to make repairs as needed. Joint efforts are needed to address the impact of contaminated land and water from waste, weed sprays, fertilizers and other pollutants.

7. Data and Research

Two issues were raised in regard to data and research. Those included making community specific health care data more accessible to tribal communities and establishing a national database of companies that can provide assistance to tribal programs such as pharmaceutical companies.

C. Actions Taken by HHS since the Listening Councils

Verbatim transcripts from each of the five Listening Councils were made available to tribal leaders for the meeting in which they participated. The 52-crosscutting/national issues were forwarded to the appropriate HHS agency(ies) for response.

A matrix which contains HHS agency responses to these specific issues was developed and reviewed during the National Tribal Consultation Forum. A summary of HHS agency responses has been incorporated into this Final Report. During the National Tribal Consultation Forum, tribal leaders and representatives from other Indian organizations reviewed the detailed responses provided by HHS to each issue. Additional issues were identified at the NTCF and recommendations made to further this dialogue and exchange. These issues can be found in Chapter III.

D. Summary of Responses from HHS Agencies by Major Themes

This section of the Summary Report condenses Agency responses within the seven major themes that emerged at the five regional Listening Councils.

1. Funding and Budget Issues

There were twenty individual issues raised under this category which fall within one of five sub-categories: (a) Appropriation Levels; (b) IHS Allocation Policies; (c) Congressional Mandates; (d) Administration Policies; and (e) Patient Generated Revenues.

(a) Appropriation Levels: Recommendations for increased funding for specific types of services such as transportation, CHRs, water and sewer systems, facility construction, traditional healers, prevention, and CHS received specific responses from the IHS. The Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), the Health Care Financing Administration (HCFA), the Administration on Aging (AOA), the Agency for Healthcare Research and Quality (AHRQ), the Administration for Children and Families (ACF), and the Centers for Disease Control and Prevention (CDC) also commented regarding the appropriations process and its impact on each agency's ability to meet certain health care needs.

IHS formally includes tribal leaders and Indian organizations in the annual budget formulation process, enabling them to identify target funding to meet priority health care needs. It is a comprehensive process in which tribal leadership works to reach consensus on funding priorities. The authority of the Snyder Act (25 U.S.C. 13) provides basic authority for most of the health care services provided by the federal government and those services identified by tribal leaders for increased funding. In meeting the priority needs identified by tribal leaders the primary limitation is the level of funds appropriated by Congress each year, the budget lines associated with the appropriation, and the fact that the IHS is not an entitlement program. The IHS is a discretionary program that depends on an annual appropriation.

Other federal agencies, such as AOA, HRSA, SAMHSA and ACF provide funding for certain types of health care services. Their funding authority is not as broad as that allowed IHS under the Snyder Act, but generally tied to a specific service or target population. These agencies are also subject to annual appropriations.

HCFA responded to these issues as well, providing information about the Medicaid and Medicare programs and the services that are eligible for coverage under each. Unlike discretionary programs, the Medicare and Medicaid programs are entitlement programs and funded differently. HCFA does not submit an annual appropriations request for Medicare benefits, but the benefits are paid on the basis of a permanent, indefinite appropriation authority. Medicaid is a "Federal-State" program in which both the federal government and the states pay a portion of the cost of the program under current law the federal government is only permitted to make matching payments to states, the District of Columbia, and territories. Changes to federal law would be required to allow similar payments to be made to tribes.

(b) IHS Allocation Policies: There were numerous issues raised regarding the way in which funds appropriated to the IHS are allocated among the twelve IHS areas and the many individual tribes and communities. Issues were raised regarding the "equity" of the current distribution methodology for base funding as well as for special funding, such as the diabetes initiative. Several ongoing efforts by the IHS are targeting the disparity in health resources that exists across Indian country. The extensive
consultation with tribes in the budget formulation process allows tribes to target funding to meet priority health care needs. A study is currently underway to examine health-funding parity for Indian people compared to the Federal Employees Health Benefit Plan. This study, known as the Level of Need Funded (LNF) study, uses actuarial methods to estimate the costs of a mainstream benefits plan for Indians. Consultation with Indian tribes is ongoing about the possibility of using LNF study results in new resource allocation formulas to address the inequities within Indian country. Regarding diabetes funding, the IHS established its allocation policy for these funds in consultation with tribal leadership and continues to meet with a Tribal Diabetes Advisory Committee regarding allocation and other concerns.

(c) Congressional Mandates: Several issues were raised that relate specifically to actions taken by Congress that affect the ability of tribes and IHS to provide health services to Indian communities. Those issues include the "moratorium" that Congress placed on further contracting of IHS services under the P.L. 93-638; inadequate funding for CSC associated with administering P.L. 93-638 contracts; use of Medicare and Medicaid revenues to offset the IHS budget; restrictions preventing the IHS from entering into a risk-based capitated plan; and the moratorium on final rules for IHS eligibility. Each of these issues had a significant impact on tribal and Indian communities. The IHS responded to these issues, stating its support and advocacy for full funding of CSC. In FY 2000, the IHS adopted a revised policy on CSC after undergoing an extensive tribal consultation process to ensure equitable distribution of any funding made available for CSC. In addressing the inequity in CSC funding, the IHS policy abandons the historic approach and the maintenance of a "queue list" in favor of a distribution methodology whereby tribes received additional CSC funding proportionate to their overall CSC needs. The IHS continues to support tribes and tribal organizations contracting under P.L. 93-638 and opposes any moratorium. The FY 2000 Consolidated Appropriation Act was signed into law in November 1999, and lifted the previous moratorium on contracting.

Regarding the use of anticipatedMedicare/ Medicaid revenues to offset the IHS budget, both IHS and HCFA cited the IHCIA (P.L. 94-437, Title II, Sec. 207(b)), which explicitly prohibits the IHS from using the amounts generated to offset the IHS budget. IHS stated that it has done significant work to increase third party collections from Medicaid in recent years and does not believe that these increases have made appropriations requested or provided for IHS smaller than they would otherwise have been. IHS will continue to work with HHS, OMB and the Appropriations Committees in making the most compelling possible case for increased appropriations.

Regarding the other congressional mandates, such as the moratorium on final eligibility rules and restrictions on IHS participation in capitated managed care plans, the IHS responded by citing the specific mandate in Federal law. Lifting the final rule on eligibility will require new law, which is proposed in current drafts reauthorizing the Indian Health Care Improvement Act. Similarly, for the IHS to participate in a capitated managed care plan, federal law would be required to lift restrictions of the Anti-Deficiency Act.

(d) Administration Policies: The most significant funding and budgeting issues raised regarding overall Administration policies is the inequity of funding for Indian health in comparison to other populations and other federally funded health care programs. Tribal leaders are seeking fairness and proportionality in the allocation of all HHS resources to Indian populations. The following HHS agencies responded to this issue: IHS, AOA, HCFA, AHRQ, CDC, HRSA, IGA, and SAMHSA. The IHS has developed a formal consultation process to involve tribal leaders in its budget formulation. The AOA held a Tribal Listening Session in August 8, 2000 to provide tribal leaders the

opportunity to express their concerns, comments and ideas. CDC reports that it will conduct an annual AI/AN Budget Planning and Priorities Meeting and implement its tribal consultation policy. CDC held its first budget consultation in March 2000 and provided a list of Requests for Proposals (RFP) that are currently available to tribes. HRSA plans to hold a budget meeting in 2001 in preparation for FY 2003 budget formulation. IGA and ASMB organize an annual budget consultation for HHS. HCFA participated in the April 10, 2000 budget meeting with tribes and is reviewing tribal budget recommendations. SAMHSA will continue to provide technical assistance workshops to assist potential applicants for discretionary grants, which tribes are eligible to attend.

(e) Patient Generated Revenues: There were many issues raised and recommendations made regarding patient generated revenues, primarily regarding Medicare, Medicaid, and managed care systems. The tribes, tribal organizations and urban health providers are becoming more dependent upon their ability to generate revenue through patient visits by billing third-party payers. As states undergo efforts to control health care costs, primarily through the use of managed care organizations to provide services to Medicaid patients, the IHS, tribes and urban providers are affected. Concerns were expressed about decreased Medicaid reimbursements resulting from state's implementation of managed care programs. HCFA has been working with states and tribes to address this issue and to explore alternative payment methodologies for IHS/Tribal/Urban providers. Both Arizona and Oklahoma have already incorporated alternative payment methods into their Medicaid payment systems. As viable alternative payment approaches are identified, HCFA will share them with tribes and states. HCFA asserts that it will work with states and the tribes through consultation and provision of technical assistance to increase I/T/U access to managed care contracts in an effort to mitigate any negative impact on the provision of health care to AI/ANs.

2. Services and Service Provision

With respect to this category, the tribal leaders generally are seeking a broader scope of services for Indian people, access to traditional and holistic interventions, and better access to alternative coverage for care. The responses from HHS agencies will be discussed in these three general sub-categories.

(a) Traditional and Holistic Care: Tribal leaders and representatives from Indian organizations made several recommendations regarding improved access to and funding of traditional American Indian healing, and access to "holistic" care for Indian families. The agencies responding to these issues included IHS, HRSA, ACF, SAMHSA, and AHRQ. While the Snyder Act provides broad authority for IHS to provide a wide range of health care services, the decision about the extent to which traditional American Indian healing is incorporated into health services is a local one. IHS reports that after lengthy tribal consultation on this issue, there is no consensus among tribes regarding the role of the federal government involving traditional healing. The AHRQ funds a small number of studies on alternative and complementary medicine, some of

which are co-funded by the National Center for Complementary and Alternative Medicine at NIH. SAMHSA is currently administering a three-year discretionary grant program, "the Circles of Care," targeting tribal communities to improve the service system for children and youth with serious emotional disturbances. One of the program's objectives is to integrate traditional healing methods indigenous to the communities. Further, tribal grantees in the program are using a holistic approach to integrate services and make them family-based and culturally competent. The Commissioner for the Administration for Native Americans (ANA) has established a traditional Elders' Circle that has been engaged in discussions concerning traditional healers/practices. Each member of the ANA Elders' Circle is a traditional healer. HRSA reports on the Navajo Integrated HIV Service Delivery Model Program which will conduct a once a year comprehensive, HIV planning initiative that will define and evaluate the integration of HIV services into existing services currently provided by the IHS and the Bureau of Indian Affairs (BIA).

(b) Scope of Services: The five Listening Councils generated a long list of services that require additional support or an increase in services or development. These included access to specialty care, inpatient care, behavioral health, alcohol/substance abuse programs, health education, long-term care, home- and community-based care, dialysis units, cancer screening for men, 24-hour emergency coverage and other services. Tribes urged IHS to help license providers and facilities in this regard. The major obstacle to addressing the need for an increased scope in services is the lack of adequate appropriations. These issues are addressed in the Funding and Budget section of this report. The authority for the IHS to meet these added services exists largely under the Snyder Act. HCFA funds dialysis units, but providers must make requests to HCFA or HCFA contractors to become eligible to provide services. The IHS senior clinician in renal disease has been analyzing the data sets of both IHS and HCFA regarding the issues of treatment of end stage renal dialysis (ESRD) and visited many communities to review the issues locally. He will provide his analysis to tribal leadership considering expanding dialysis activities or other approaches to treatment of ESRD. HRSA's activities and partnership with IHS provides support for American Indian emergency medical services programs throughout the U.S. Support is provided for expert medical direction, training, and other services to more than 100 tribal EMS programs. The IHS has worked with tribes to develop a more comprehensive definition of alcohol services in the draft language for the reauthorization of the Indian Health Care Improvement Act. IHS has worked with the Youth Regional Treatment Centers to evaluate the efficacy of the programs and identify linkages with community aftercare services, and IHS has worked closely with the Department of Justice to improve case finding and treatment programs for juveniles in trouble with the law who may have alcohol related illness. IHS has also has placed an Indian alcohol specialist with the Center for Substance Abuse Treatment to advocate for resources targeting Indian Country. For Diabetes, IHS proposed and received increases in the FY 2001 budget to assure recurring funds are available to support the new diabetes activities funded by the BBA of 1999 to assure long-term availability of these programs. IHS has worked with NIH to expand tribal participation in research planning and design targeting Indian Country, and IHS has worked with tribes to

develop the Diabetes Prevention Research Center in New Mexico to assure long-term evaluation of the most effective prevention interventions. For SAMHSA, alcohol and drug abuse funding is provided to AI/AN populations in part through its discretionary programs. For example, tribal populations have been a focus under the Targeted Capacity Expansion program, which has been successfully accessed by tribes in recent years. In the future, Tribal Colleges and Universities administrative grant representatives will be invited to participate in all SAMHSA-sponsored technical assistance workshops relating to enhancing competitiveness for funding of substance abuse and mental health prevention and treatment activities.

(c) Access to Coverage: Issues were raised regarding access to "charity care" programs for Indian populations, barriers to Medicaid and increased outreach for Medicare and Medicaid enrollment. These issues were referred to IHS and HCFA for response. With regard to "charity care," HCFA responded that a Medicare payment adjustment is provided for hospitals that serve a disproportionate share of low-income patients. The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location. IHS or tribal hospitals that are Medicaid providers may qualify for additional payments above the state plan rate as Disproportionate Share Hospital Payments (DSH) facilities pursuant to Section 1923 of the Act. HCFA will communicate to states that DSH payments are available for IHS and tribal hospitals.

Regarding access to Medicaid coverage, HCFA regulations (42 CFR 435.930) require states to provide Medicaid coverage to all persons who have not been properly determined to be "ineligible" for Medicaid. States must affirmatively explore all categories of eligibility before it acts to terminate Medicaid coverage. HCFA has awarded contracts to provide information to AI/ANs about its major programs, including projects with tribes to develop outreach materials regarding Medicare + Choice and related programs. In addition, HCFA has funded a larger initiative that produced outreach materials for elderly and disabled AI/ANs who may be eligible for Medicare and Medicaid.

3. Care Providers

There were two issues raised regarding care providers. The first dealt with the need for more providers to provide needed care; and the second dealt with the need for IHS to assist in licensure of health providers from other states assigned to tribal health facilities. HRSA, IHS, and SAMHSA addressed these issues. With regard to the need for more care providers, IHS points to the P.L. 94-437 and its following programs: the IHS Scholarship Program (sections 103 and 104), the Loan Repayment Program (section 108), grants to public and nonprofit health and educational entities to provide training (section 102), recruitment activities (section 112), support for nursing schools (section 118), professional scholarship programs (section 120), and section 217, which provides grants to three colleges and universities for psychology recruitment. The IHS continues to pursue salaries

competitive with the private sector to recruit and retain health professionals. SAMHSA provided information about the Office of Minority Health Washington Internships for Native Students program which supports summer internship placements at Tribal Colleges and Universities to train AI/AN students in substance abuse and behavioral health fields. HRSA administers grant programs in the areas of nursing, Allied Health, medicine, dentistry, psychology, and recruitment. With regard to licensure, the IHS responded that it advocates for licensure of all health care providers. Licensure is between the state of jurisdiction, the employing tribe or tribal organization, and the individual provider.

4. Facilities, Equipment and Supplies

Four distinct issues came within this category. The first issue was the general lack of health care facilities, including clinics, nursing homes, chemical dependency units, renal dialysis units and emergency rooms. Another issue addressed the ability of IHS and tribal facilities to meet Joint Commission on Accreditation of Health Care Organizations (JCAHCO) standards. The third issue concerned dissatisfaction with the current IHS facility construction priority system and the need to examine alternative financing options. The final issue in this category addressed the need for disaster preparedness equipment.

The agencies that responded to these concerns include IHS, HCFA, HRSA, AOA, and SAMHSA. SAMHSA reported that although it is authorized to fund services for treatment, these funds may not be used for construction of facilities for such programs, although rental and other facility overhead costs may be reimbursable expenses. Regarding alternative financing options, the IHS referenced a roundtable held to address this issue. A document, "Report of Roundtable Discussion and Analysis of Future Options for Indian Health Care Facility Funding," was disseminated to all tribes. Utilizing Medicare and Medicaid revenues, the IHS and tribes are addressing renovation and expansion projects including upgrade of emergency rooms and other facilities. As replacement projects are being processed in the IHS Health Facilities Construction Priority System, upgraded emergency rooms are being considered.

HCFA responded that the accreditation requirements are described in 42 CFR 488.4 to 488.11 for accrediting organizations, such as JCAHCO. The Survey and Certification Group in HCFA's Center for Medicaid and State Operations proposes a two-tiered approach to the issue of how tribally-owned facilities that lack sufficient capital could become accredited. HCFA proposes to ask JCAHCO to allow the accreditation fees for tribally owned facilities to be waived or offered at a reduced rate, or at least be included under the same rate setting as the IHS.

Since 1980, IHS has supported postgraduate training in institutional environmental health to ensure that a cadre of highly trained specialists are trained to enable IHS and tribal health care facilities to meet all applicable regulatory guidelines and standards. Currently, seven of the IHS areas have full time Institutional Environmental Health Specialists on staff to address JCAHCO and other regulatory issues. HCFA is establishing a workgroup to determine possible changes in surveying tribal facilities.

Regarding the dissatisfaction with the IHS Health Facilities Construction Priority System Methodology, the IHS responded that extensive consultation regarding the reauthorization of the P.L. 94-437 has occurred. IHS anticipates that further tribal consultation will lead to beneficial changes to this system.

The OPHS responded to the issue of disaster preparedness equipment. During Presidential declared disasters or major emergencies, health and medical response assets, with appropriate medical equipment, is furnished through Emergency Support Function #8 (Health and Medical Services) of the Federal Response Plan, by activation and use of the National Disaster Medical System. The IHS seeks funds to provide one time funding to tribes and tribal organizations to purchase emergency response equipment. Since 1990, approximately $2 million has been provided to tribes and tribal organizations to fund injury prevention projects, and to purchase EMS equipment.

5. Intergovernmental Relations and Related Issues

With respect to intergovernmental relations, the tribes' issues can be divided into three subcategories: (a) structure and process; (b) new initiatives; and (c) changes in law.

(a) Structure and Process: It was recommended that the HHS establish an advisory body that includes tribal leaders and establishes "Indian Desks" at all the HHS agencies to provide better access to programs and enhance communication. Tribes also wanted to know the specific actions HHS planned to undertake to document, investigate, and respond to each of the issues raised during the Listening Councils, as well as at future tribal consultations. Some participants voiced concern about "consultation overload," and suggested that HHS employ one system or process for providing input. It was recommended that "key staff" be identified in each agency of HHS and the Office of Intergovernmental Affairs in the Office of the Secretary (IGA) coordinate all tribal issues. HHS will examine the proposal of establishing a departmental advisory body that includes tribal leaders. Another possible approach to consider is to expand the HHS Inter-Agency Tribal Consultation Workgroup (which is co-chaired by the Directors of the IHS and the IGA) to include tribal representatives.

IGA, which is the HHS liaison to state, local, and tribal governments, is the lead office for tribal consultation. IGA, along with the Office of the Assistant Secretary for Management and Budget, annually convenes a meeting of tribal leaders and Indian organization representatives to discuss with HHS leadership tribal appropriation needs and priorities for the following budget cycles. All HHS agencies responded to the budget consultation issue by underscoring their intent to either continue or to initiate an annual tribal budget consultation process. In addition, all HHS agencies have formulated consultation plans which are being reviewed by the tribes. Most of the agencies have scheduled tribal consultation sessions to formalize this process.

(b) New Initiatives: Tribal leaders suggested new or expanded initiatives beyond the Department and involving other entities, such as HHS/tribal partnerships and other means of collaboration between the tribes, the states, the private sector and HHS. Interdepartmental coordination will be needed to assist tribes in addressing issues related to international borders, such as drug trafficking and child custody issues. IHS responded that a sub-group of the HHS Interagency Tribal Consultation Workgroup could be charged to meet with tribal leaders and/or their representatives to discuss the issue of partnering with private entities, and to call upon state government officials to explore enhanced collaboration.

ACF identified numerous situations and programs involving partnership with Indian communities and states, in particular related to welfare reform, TANF and child support enforcement. The Office of Child Support Enforcement (OCSE) will be providing direct federal funding to AI/AN under Section 455(f) of the Social Security Act to operate their own Tribal Child Support Enforcement Act upon publication of a final rule.

HCFA identified numerous instances of collaboration between HCFA, tribes and the states and voiced its commitment to continue working to develop these partnerships to improve the delivery of services to AI/AN beneficiaries under Medicare, Medicaid and SCHIP.

CDC is proposing to engage the Council of State and Territorial Epidemiologists (CSTE) in the planning and development of surveillance systems for AI/AN communities, including urban Indian populations, and to encourage tribal government participation in the CSTE. IGA, along with all HHS agencies, will work with the national intergovernmental organizations, such as the National Conference of State Legislatures, the National Governors Association, National Association of Counties, and the U.S. Conference of Mayors to formulate tribal/state partnerships and opportunities for collaboration.

In FY 2000, SAMHSA issued a priority initiative for Community Action Grant for Service Systems Change for American Indian Alaska Native Youth. This grant offering was part of an interagency effort to provide tribes with easy-to-access assistance in developing innovative strategies that focus on the mental health, behavioral, substance abuse, and community safety needs of American Indian young people and their families through a coordinated Federal process. Federal partners in the initiative were the Indian Health Service and the Departments of Justice, Education, and the Interior.

HRSA's Healthy Start initiative has provided approximately five million dollars to three tribal governments.

(c) Changes in the Law: Several of the recommendations made during the Listening Councils involving intergovernmental relations would require new legislation or changes to existing law. One of the most frequently mentioned change, is the elevation of the IHS Director position to an Assistant Secretary. There have been several bills introduced in the Congress to achieve this change. The Secretary of HHS supports the elevation.

Tribes have also asked that the cap on indirect rates for Head Start be lifted and tribes be allowed to charge a more realistic rate. ACF responded that the law sets limits on costs of development and administration of Head Start and Early Head Start programs. An administrative waiver is available to exceed the 15% threshold only for a specific time period not to exceed 12 months.

6. Infrastructure

Tribal leaders expressed concern about the deterioration of water and sewer infrastructures in Indian communities. Assistance is requested to repair and replace these systems, including adequate funding for ongoing maintenance and improvement. Training is recommended for tribal communities to conduct their own repairs of these systems rather than depend upon other resources. A joint effort to address the impact of contaminated lands and water from waste, chemical sprays and fertilizers is recommended. The IHS was the only agency to respond to this issue. The IHS, under the authority of the Snyder Act, the IHCIA, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act provides technical assistance to tribes on environmental health issues and authorizes tribes to operate certain environmental health programs. The IHS provides funds to upgrade service to existing Indian homes. Projects to upgrade existing community facilities are funded based on each IHS Area's priority system. The projects are scored on the priority system based on health risk, capital cost, deficiency level, and tribal priority. The IHS plans to upgrade services to 9,300 previously served homes in FY 2000 and 9,660 previously served homes in FY 2001. The IHS budget includes $1,000,000 annually for training personnel from tribal operation and maintenance organizations. The IHS will continue to update the sanitation facilities priority system annually and consult with tribes on their sanitation facilities needs and priorities.

Concerns regarding contaminated lands and water in Indian communities have also been referred to the Environmental Protection Agency (EPA). Additional follow-up may be needed on issues, such as this one, which require the coordination of other departments.

7. Data and Research

Data systems currently available to IHS and tribal health systems should do more than simply generate billing or patient encounter information. Tribal leaders are interested in user-friendly data systems that can provide community-specific health care data and track health status of the patient population. The utility of the data systems for local planning and priority setting should be assessed and corrected, if needed. In addition to local data systems, the tribal leaders asked that the Federal government assist in establishing a national database of pharmaceutical and other companies that provide assistance to tribal health efforts.

All HHS agencies were asked to respond to the issue of local, community-specific data systems. The IHS response included background on section 602 of P.L. 94-437 which establishes an "Automated Management Information System" to be established by IHS. This system has evolved into today's "IHS Resource and Patient Management System"

(RPMS) that collects both clinical and administrative data. Data is generated at the local level and forwarded to the Area, which in turn sends it to the IHS National Data Repository in Albuquerque where it is aggregated for national purposes. This aggregated data is used primarily for statistical analysis and reporting to Congress. IHS reports that the RPMS already can provide local data requested by tribes, except for a possible lack in staffing to extract data or insufficient training at the local levels. Tribes may not be aware of the reports that can be generated locally.

The Division of Information Resources (DIR) Information Technology Support Center in Albuquerque has provided a series of RPMS training sessions and a national Help Desk for local customers. The IHS also makes information available through the National Data Repository, the Internet, and Epidemiology Centers (Epi). Several of the four Epi Centers have developed innovative strategies to monitor the health status of tribes and use sophisticated record linkage computer software to correct existing state data sets for racial misclassification. These Epi Centers provide immediate data feedback for self-governed tribal health programs to plan and decide the most efficient and effective health care services for their people.

The AOA, through the National Resource Center on American Indian Elders at the University of North Dakota, has developed a computerized needs assessment tool for tribes to use at their discretion. HCFA responded that the IHS and HCFA have formed a steering committee to address key issues of mutual concern, and is working to establish a data subcommittee to address these issues.

The CDC is working with the IHS to assist tribal governments in developing health data systems that have practical public health applications, such as improved disease surveillance. Pursuant to making community specific data available, CDC's National Center for Health Statistics (NCHS) has proposed two new surveys: (1) Defined Population Health and Nutrition Examination Survey (DP-HANES) to provide flexible and timely access to high quality examination and laboratory data for a range of defined populations that cannot be addressed using the standard NHANES framework. Most of the sub-populations suited to this system are not sufficiently large and/or sufficiently geographically dispersed to allow efficient data collection using a national sampling frame; (2) State and Local Area Integrated Telephone Survey (SLAITS) to track and monitor questions already existing on NCHS National Health Interview Survey (NHIS), which assesses health status, health insurance, access to care, and health risk factors and behaviors. CDC also periodically publishes Mortality and Morbidity Weekly Report articles addressing public health issues of importance to AI/AN communities.

HRSA responded that the Office of Minority Health/Office of the Secretary is currently finalizing the Joint Report of the HHS Data Council Working Group on Racial and Ethnic Data and the Data Work Group of the HHS Initiative to eliminate Racial and Ethnic Disparities in Health. IGA will continue to work through the Inter-Agency Tribal Consultation Workgroup to institutionalize the Department's Consultation Policy and address issues such as this. SAMHSA reported that Centers for Substance Abuse Prevention (CSAP) is funding a feasibility study to develop local infrastructure necessary to collect data in AI/AN communities.

This data was collected in two communities and will give tribes a more accurate snapshot of the incidence and prevalence of substance abuse-related violence, especially domestic violence. CSAP is also engaged in the task of developing culturally appropriate measures for substance abuse prevention problems and efficacy in their unique prevention programs, through the "Cultural Core Measures Initiative."

Finally, AHRQ responded that it has discussed incorporating IHS data into the Health Cost and Utilization Project (HCUP), a Federal-State-Industry partnership to build a standardized, multi-state, longitudinal data system. Presently, HCUP includes inpatient data and is managed by AHRQ. AHRQ has also discussed doing an oversampling of Indians in the Medical Expenditure Panel Survey (MEPS) with the IHS in order to be able to produce data for AI/AN. MEPS is a nationally representative survey of health care use, expenditures, sources of payment, and insurance coverage for the U.S. civilian non-institutionalized population, as well as a national survey of nursing homes and their residents. MEPS is co-sponsored by the AHRQ and the NCHS. Oversampling would produce national, not community-specific data, and would be very costly.

With regard to the request by tribal leaders to develop a national database of pharmaceutical and other companies that provide assistance to tribes, the IHS responded that a national database of patient assistance for prescription drugs has been established by the Pharmaceutical Research and Manufacturers of America. A complete directory of pharmaceutical companies offering these services can be found on the Internet at www.phrma.org/patients. HCFA has provided similar lists to the IHS and will furnish source lists of pharmaceutical companies having drug assistance programs.

Chapter III–National Tribal Consultation Forum

In July of 2000, the Department convened tribal leaders from all across the nation for a National Tribal Consultation Forum with top representatives from each of the Operating Divisions. This gathering was convened by Deputy Secretary Kevin Thurm and moderated by tribal leaders representing national Indian organizations. The format for the two-day meeting included presentations by panels of agencies within DHHS responding to the concerns voiced by tribes during the five listening councils. Following each panel presentation, tribal leaders and Indian organization representatives were provided time to ask specific questions or to make statements. A summary of new issues raised at this national meeting is reflected in later sections of this report. The agenda also provided time for tribal leaders to breakout into smaller workgroups to develop specific action-oriented recommendations around 7 major issue categories identified during the five listening councils.

A. Tribal Recommendatons on Major Themes

The seven (7) work groups met for an hour and a half to address the specific responses provided by OPDIVS in a draft document. From these seven work groups the following recommendations were made:

1. Funding and Budget Issues

Lack of Funding. Establish a line item budget, support appropriation for health services at the "level of need." Create a Work Group comprised mostly of tribal and some HHS personnel to assess HHS funding and unmet needs in Indian Country which will be one year or more in duration. Analyze federal funding, awarded by direct and block grants, by population through tribes, tribal organizations and state/county governments, under GPRA and/or other means.

Lack of Funding for water/sewer maintenance. Appropriately fund maintenance and improvement. (1) Ensure adequate funding and emphasis by IHS to monitor and assess water borne diseases. (2) Continue efforts in both IHS, CDC (with support by the DHHS) to increase funding for capital construction.

Lack of Funding to build, expand, replace and maintain health care facilities. Fund innovative financing for tribes to build health care facilities. Create a tribal workgroup as a sub-work group or committee on Facility Construction to assist the DHHS funding workgroup in exploring new non-IHS construction funding options.

Lack of funding for Traditional Native Healers/Native Practices.(1) Have HCFA institute a waiver to allow native healers to be reimbursed by states through Medicaid and other programs. (2) Continue to support amendments to Title IV of the Indian Health Care Improvement Act reauthorization bill, which expands reimbursement for traditional healers.

Lack of funding for prevention activities. The funding is only enough to address primary care. Create a sub-work group on prevention to meet in conjunction with the DHHS funding workgroup to assess Block Grants and/or other funding for prevention initiatives.

Underfunding of CHR and Clinical Health Nurse Programs and earmark of funds for CHS and increases for CHS. Continue to address through the IHS Budget Formulation Process.

Appropriate additional funds for EMS, elder care, alcohol prevention and treatment. Commit to a long-term diabetes initiative in Indian country. To compliment the HHS funding work group, create a "services" subcommittee or sub-workgroup to address funding needs in these areas in chronic and infectious diseases.

2. Services and Service Provision

Specialty Care. (1) Provide non categorical funding for pilot programs in the design of comprehensive systems, including specialty care (joint venture) (HRSA). (2) Institutionalize the pilot programs that are successful.

Dialysis. (1) We must find the means to access additional funding for kidney dialysis in Indian communities. (HRSA, NIH). (2) Develop consumer friendly educational materials on diabetes and kidney disease; expand successful preventive programs including staged diabetes management.

Cancer Screening for Men. (1) Access additional fiscal resources from DHHS agencies beyond the IHS to expand cancer screening services to both genders. (2) Ensure reimbursement for prevention services to get men screened and treated earlier, which will outweigh the more costly late-stage treatment efforts.

Lack of access to charity care. (1) HCFA encourage states to provide DSH funding to IHS and tribal hospitals (a letter is going out, but a problem in the definition of a hospital is greater than 16 beds.) (2) Work with HCFA to expand DSH payments to I/T/U programs through legislative and regulatory means.

Traditional Healers. (1) HCFA should work with state Medicaid programs to encourage and support a means to include reimbursement for traditional medicine. (2) HCFA support for legislative changes in IHCIA regarding traditional healers.

Medicaid services to unmarried couples. States cannot deny Medicaid because of the parent's marital situation, yet this is an obstacle for many Indian families. HCFA must work with the states and tribes to overcome this barrier for tribal families.

3. Care Providers

The present health professional resource situation is that there are just too few providers in critical areas and there is a high patient care load. There is a specific need for more psychiatrists, mental health professionals, and counselors trained in inhalant abuse. Tribal communities also need more Community Health Representatives (CHR's) and more Clinical health nurses. To address the many health professional shortages in Indian communities, tribal leaders made the following recommendations.

Incentives: IHS must use existing options to encourage careers in IHS, and other Indian health care facilities, such as the Federal loan repayment programs and scholarships and enhancement training of Native Americans in the health professions. School Linkages: Look at how to enhance relationships with schools producing physicians, nurses, and other health professionals. Encourage cooperative learning experiences between local health facilities and local school districts and college work study programs for youth to encourage interest in health professional careers.

Multi-agency Work Group: Establish multi-agency working group on health professions and Indian health with tribal participation. Establish a work group as a standing committee to look at issues (i.e., retention incentives, building educational capacity at the local level and help tribes bring it together).

Department of Justice Coordination: To assure appropriate levels of qualified mental health, chemical abuse and law enforcement staff and services, need to engage the Department of Justice.

Cross-cultural training: Ensure that cultural sensitivity education is provided for providers and communities throughout the I/T/U system.

Catalogue "best practices": Capture "best practices" and catalog programs with a cultural orientation used successfully in communities.

CHR Development: Enhance training and career development pathways for CHRs

Continuing education: Identify and develop distance learning options for continuing education credits.

4. Facilities, Equipment and Supplies

Tribes are operating under in a "crisis mode." Tribes are caught in the difficult position of trying to provide health services with less than adequate resources in facilities which are outdated and ill-equipped or the challenge. In addition, tribes need to continually devote time and energy to educating the federal agencies regarding the specific, varied and unique challenges to providing health care to American Indians and Alaska Natives.

IHCIA Reauthorization: Strong support and lobbying is needed to push through the tribal consensus amendments to Indian Health Care Improvement Act (IHCIA), Title III Facilities section.

Appropriations: Support and advocacy is needed for annual Interior appropriation bills in FY2001 and FY 2002 for facilities construction, equipment and sanitation.

Tribal committee: National tribal committee to review health care facilities methodology and develop a needs inventory

Steering committee: Dr. Trujillo, IHS Director, approved concept for a steering committee to develop the priority list and review the health care facilities methodology to endorse and support this steering committee.

Support for tribes already on the priority list: Endorse IHCIA recommendation to grandfather those tribes that are on the priority list.

Recurring construction funding: Begin to support legislation for recurring base funding through the IHS budget process, the current estimate is $170 million. Need to have a long-term commitment for facilities for IHS tribes and the Office of Management and Budget.

Disaster preparedness plans: The IHS needs to identify what each tribe has/needs for disaster planning and preparedness.

Emergency Medical Services: Need to identify the ambulance needs for each tribe.

HHS field visits: Tribes need to make an effort to invite all the Department heads to tribal communities to that they gain a real understanding of the challenges faced by tribal leaders and health care providers. There should be an ongoing commitment by tribes to continue inviting HHS department heads to Indian Country.

Indirect cost assistance: The IHS and HCFA will provide assistance to tribes in determining a formula to determine indirect vs. direct funding.

Accreditation costs: HCFA needs to assist in researching alternatives to the high-cost of JCACHO accreditation for Medicare and Medicaid funding.

5. Intergovernmental Relations and Related Issues

Partnerships: There is a need to explore new and creative approaches and partnerships for efficient delivery of services to tribal communities and encourage collaboration between state and tribal governments. Agencies of HHS should assist in helping private businesses become health care partners with tribes.

(1) Agencies encouraging states to work with tribes

(2) Convene a meeting with the National Governors Association (NGA), state health directors, tribal leaders, and program staff to discuss collaborative opportunities.

(3) Talk to states and tribes about "best practices" and impose conditions that accompany federal funds to states, to work with tribes or else lose a portion of state Block Grants; tribes should have direct access to these resources.

(4) Help maximize tribal access to state health resources.

(5) Educate U.S. Congressional members, states representatives, etc., about tribes as governments, tribal capacity, etc.

(6) Use maximum flexibility in working with tribes unless prohibited by law, develop policy guide.

(7) Identify the parameters within various discretionary programs, such as "eligibility" and work to improve access for tribal patients.

(8) Seek federal legislation which would authorize direct funding to tribes or require state agencies to work directly with tribes in implementing federal health programs.

(9) HHS mandate as a directive that states provide appropriate funding to tribes.

(10) Seek language in Appropriations bill which will set-aside specific allocations for tribes in each HHS program as opposed to seeking changes to authorizing statutes.

(11) Work through the budget formulation process to increase HHS funding for tribal and other Indian communities.

(12) Bring the issue of disproportionate underfunding of Indian health to the international level for discussion.

(13) Nurture the tribal/federal agency relationships at regional levels.

(14) Work with state agencies through cooperative agreements to improve the situation of Indian health in each state.

(15) Look to the several "Intertribal Councils" as means to work together on state and tribal issues.

(16) Closely examine existing HHS Block Grants to states to determine all possible ways to encourage and increase tribal participation. Establish a requirement to report federal funding going to states to the tribes. HHS Office of Intergovernmental Affairs should put pressure on the states to better work with tribes.

(17) Participate with the National Governors Association to begin discussions about HHS Block Grants to states and tribal participation.

(18) DHHS agencies should help facilitate tribal/state relationships, as stated in the HHS consultation policy, through the IGA.

(19) State Plans for specific Block Grants programs should be shared with tribes so that tribes will know what services are provided, which populations are targeted and counted and the amount of federal resources provided.

(20) GPRA requirements should be enforced which would support state consultation with tribes as a part of the New Federalism.

Advisory Boards: In regards to the establishment of a Departmental advisory body which includes tribal leaders the following specific recommendations were made.

(1) Institutionalize a tribal voice in policy-making.

(2) Extension of the consultation steering committee.

(3) Tribes create this Advisory Board with a list of contacts for consultation purposes depending on the issue.

(4) The Office of General Council will check the rules on Advisory Boards.

(5) Intergovernmental Affairs will staff the Advisory Board.

Follow Up: Regarding planning and follow-up to this and future "consultation" meetings or Listening Councils, the following recommendations were made.

(1) Elevate the priority of tribal consultation with additional staff.

(2) Publish in the Federal Register as soon as possible, the consultation schedules for the next year to help with the transition, including budget, legislation, and programs.

(3) Information to tribes about IHS design of the Final Report

(4) Some state funding identified/earmarked for Indian programs

(5) HHS can help with technical assistance

(6) Identify Block Grants with restricting language and those that are open

(7) HHS IGA should sit-in on Alaska government-to-government meetings.

(8) There should be ongoing funding or a "tap" to support tribal consultation activities.

(9) IGA should issue a Draft Plan and schedule of follow up meetings

(10) Look to regional "Intertribal Councils" and other Indian organizations for strategies, coordination and direction.

(11) The National Congress of American Indians (NCAI) should provide its resource guide to the HHS Intergovernmental Affairs office immediately and routinely.

(12) This Final Report for the National Listening Forum must include the responses received back from individual Operating Divisions of HHS. Seek comments on format of the report.

(13) HHS will list the "point of contact" for each of the HHS agencies as a part of the Final Report for central office and regional offices.

(14) Provide time at future national meetings for updates about this and future consultation progress.

(15) All DHHS agencies send budget information to tribes for opportunity to react.

6. Infrastructure

(a) Continue increases to SDS budget (IHS/DHHS)

(b) Continue to lobby in support of tribes;

(c) Collaborate with other departments and agencies, such as the Environmental Protection Agency (EPA), USDA, etc., on funding projects. This would be similar to what DOJ, CPO and BIA did in the construction of detention facilities. DOJ-CPO constructs and BIA staff facility, maintenance and operation. Tribes can contribute to projects which increases the changes of funding

(d) Facilities Backlog Advisory Board of IHS should continue looking at alternatives to the construction priority list.

7. Data and Research

(a) HCFA and IHS will incorporate an "Advisory Committee" to meet with a group of experts to review the current data collection. Proposed meeting in September of 2000. Incorporate this into the consultation protocol.

(b) Data council shall share the joint report with 558 tribes and shall attend the HCFA/IHS committee meeting proposed for September 2000.

(c) In 2001: Explore valid and reliable data to ensure accurate reporting on vital statistics and to also influence the National Policy Commission.

(d) In 2005: Morbidity and Mortality data needs to be accurate on IHS data that shall include shared data, such as for diabetes, with American Indian and Alaska Native health.

(e) In 2005: Develop a common data set for all of Indian health nationally.

B. New Issues Voiced at the National Tribal Consultation Forum

The participants at the National Listening Forum raised new issues.

Set Aside. The HHS should establish a set-aside of at least 1.5% of HHS budget which is dedicated for programs and services for Indians. This percentage roughly represents the Indian population in proportion to the U.S. population served by HHS.

Diverse Strategies. Tribes are unique. One-size does not fit all tribal communities. HHS must keep this in mind when developing strategies and initiatives for Indian country.

Unique Relationship. Tribal/federal government-to-government relationship is based on unique political, historical relationship and NOT on status as racial minority or public involvement. This needs to be clearly understood by every OPDIV.

Current Levels. What is the exact percentage of the HHS budget now going to Indians? This data must be provided for discussion and consultation between tribes and HHS to be meaningful.

Legislative Changes. Identify specific legislative changes needed to eliminate barriers preventing Indian populations from accessing HHS categorical and formula funded programs. Can tribes and HHS develop together a technical amendments bill which could correct many of the problems with existing HHS authority?

Consultation Plans. Tribes want to know the status of draft consultation plans prepared by each OPDIV, and the steps to ensure accountability to follow these plans. Each OPDIV Plan should be consistent with the Executive Order and Secretary Shalala's policy statement. It was pointed out that consultation is a "two way street" and that only 3 of the 550 tribes responded so far to the draft consultation plans.

Community-Based Research. Note of caution about using universities as the focal point for research within Indian communities. All research should go through the local tribal Institutional Review Board. Tribes should have precedence over universities for research on Indian health. There is considerable interest in the amount of funding from NIH available for Indian research. For example if the 1.5% set aside was applied to NIH's $18 billion budget, tribes could have access to $250 million in research and planning funds.

Emerging Health Issues. More attention is needed on emerging health problems such as HIV/AIDS, cancer, heart disease, diabetes, domestic violence, alcoholism/alcohol abuse, methamphetamine use, youth suicides, elder care, and child sexual abuse;

Pre-meeting Notice and Document Review. There needs to be adequate notice of these type of meetings with time to review documents in advance.

HCFA Definition of "Encounter." Repeated concerns about the lack of a consistent definition for an "encounter" by HCFA. This needs to be resolved in consultation with tribes. The current "rural rate" is too low. There needs to be an all-inclusive rate for dual-eligible patients.

States Reluctant. States continue to be reluctant or even refuse to engage in meaningful discussion and consultation with tribes on many of these issues. There could be civil rights violations in the way some states have systematically excluded tribal participation in resources. One example, was the refusal by the State of South Dakota to certify nursing homes on Indian reservations with certificates of need and thus prevent access to Medicaid reimbursements. The State of Idaho refuses to pay the encounter rate to tribes. There was a request for review by the Office of Civil Rights with regard to South Dakota.

HCFA/IHS Demonstration Must Include Tribal 638 Contractors. The proposed demonstration project being planned between HCFA and the IHS to eliminate IHS facilities from cost reporting requirements should also include tribal 638 contractors. Not all tribal contractors are FQHC and could benefit from this coverage.

Direct Funding of Tribes. Tribes should receive funding directly from the federal government and not be forced to go through the states to access federal health and human service resources, such as services for Severely Mentally Ill (SMI) populations and other HCFA resources.

Devolution. Tribes are concerned about the trend toward devolution and the federal government should provide for direct funding of tribes without going through the states.

Slowness of Response. There was disappointment voiced about the slowness of responses to issues raised by tribes at the five (5) listening councils. A more expedited system is needed to provide more timely feedback and dialogue with tribes.

CDC Funding. What percentage of the total CDC budget does the current tribal funding of $21 million represent? Tribal infrastructure for public health oversight is needed and should be supported through CDC funding. There was a specific inquiry regarding the recent decision by CDC to cut by 50% its support for Native American HIV/AIDS for capacity building in Indian communities. These funds should be restored, particularly in light of the limited disease surveillance in Indian country now.

Communication. The HHS was encouraged to utilize the national Indian organizations, such as NIHB, NCAI, NCUIH to get the message out to Indian country. But, the agency should also communicate directly with the 550 tribes, as not all tribes belong to these organizations. There was also a suggestion that the IHS Area Directors be delegated the responsibility to ensure communication is delivered directly to each tribe and opportunities for feedback provided.

International Borders. Tribes along the Mexico/US border are subsidizing the cost of emergency medical care for illegal aliens injured or sick and brought to their facility by the INS. There was a request for assistance.

Indian Health Care Improvement Act. The Department has not yet taken a position on the tribal consensus bill for the reauthorization of the Indian Health Care Improvement Act. Tribes want to know what position this Administration takes on this important legislation.

Inpatient Treatment is Too Short. There was concern raised that inpatient treatment for 28 days is not sufficient to address the multiple drug, alcohol and mental health problems experienced by Indian youth. Longer treatment is needed. Also what is available for those people returning to their communities from treatment? Support for longer treatment is needed.

HHS Agency Responses to New Concerns and Issues

Issue #1: Definition of an "encounter"

The IHS and HCFA responded to the concern raised by tribal representatives about the inconsistency among federal programs in the definition of an "encounter" and the inadequate reimbursement rate or patient encounters in remote, rural communities.

Both IHS and HCFA cited Section 1911 of the Social Security Act, which provides authority for IHS facilities to collect Medicaid reimbursements for eligible patients seen in an IHS-owned or leased facility, whether operated by the IHS or a tribe or tribal organization. The IHS and HCFA have established a "Working Group" consisting of tribal representatives who are providing input into the development of a policy memorandum, which will include the definition of an "encounter", and specify what services are covered by the all-inclusive rate. It is anticipated that this policy memorandum will be applied nationally to all State Medicaid programs in which IHS or tribal programs operate. HCFA proposes to send a letter to State Medicaid directors and tribal leaders clarifying the definition of an encounter to address this concern.

Both agencies have already begun steps to address this tribal concern. Meetings were held with tribal leaders to discuss a draft policy memorandum. HCFA staff met with State Medicaid directors as well. While this is not an appropriations issue since Medicaid is funded as an entitlement, the outcome of defining what services are covered under the all-inclusive rate and the definition of an encounter, will have an impact on overall funding for tribal and IHS facilities serving Medicaid eligible patients.

Medicaid is a state-administered program. Reaching consensus among the various states and many tribes operating health services in each state could be difficult to achieve. Some of the potential strategies identified to overcome this obstacle include pending legislation in the U.S. Congress. The reauthorization of the Indian Health Care Improvement Act, if enacted as proposed by tribes, would include a new "Qualified Indian Health Program" (QIHP) which specifically establishing a national reimbursement methodology for IHS, tribes and urban Indian health providers. HHS has not taken a position on QUIP. In the mean time, IHS and HCFA continue to work with the tribes and the National Association of State Medicaid Directors' Tribal Workgroup to discuss and resolve these issues.

Key contacts on this issue are: Kitty Marx, Senior Policy Analyst, Office of Management Support, Indian Health Service (301) 443-6306; Elmer Brewster, Senior Health Specialist, Office of Public Health, Indian Health Service (301) 443-2419; Christine Hinds, Health Insurance Specialist, Health Care Financing Administration, (410) 786-4578 and Larry Reed (410) 786-3325.

Issue #2: HCFA/IHS Demonstration Project:

The IHS and HCFA each responded to the concern by tribes at the National Forum that the "Demonstration Project" contemplated by IHS and HCFA did not include tribes administering health services under the Indian Self-Determination Act (PL93-638).

The IHS and HCFA cited Section 1880 of the Social Security Act, which provides authority for the IHS and tribes to collect Medicare reimbursement for services to eligible patients, and Section 402 of the same Act which allows the Secretary to conduct the "Demonstration". These agencies reported that currently a draft proposal is being finalized through a joint working committee of the IHS, HCFA and tribes. Medicare cost reports will continue to be a requirement of all IHS and tribal hospital facilities for rate setting for purposes of Medicaid and to make sure that IHS is receiving reasonable reimbursements from Medicare. Tribal freestanding outpatient clinics are not part of the Demonstration as planned because these clinics can bill Medicare as a "Federally Qualified Health Center" (FQHC) or under the physician provider number. The Demonstration Project will change how the IHS is reimbursed Medicare payments from "fee-for-service" to a per capita amount. Appropriations will not be affected by this project, however it must be presented to the Office of Management and Budget (OMB).

Potential strategies to overcome these obstacles include the IHS looking more closely at the difficulties that facilities operated by tribes under PL 93-638, which are owned or leased by tribes face in accessing Medicare. Continued consultation with tribes on each of these issues is viewed as the key to moving forward and defining an effective Demonstration Project which can be approved.

Key contacts on this Project are: Dr. John Yao, Office of Managed Care, Indian Health Service, (301) 443-2522; Duane Jeanotte, Deputy Directory of Health Policy, Office of Public Health, Indian Health Service, (301) 443-1083; Elmer Brewster, Third Party Administrator, Office of Public Health, Indian Health Service (301) 443-2419; and Ann Pash, Health Care Financing Administration, (410) 786-4516.

Issue #3: Center for Disease Control and Prevention Funding

CDC responded to the concern expressed by tribes at the National Tribal Consutation Forum seeking clarification regarding the percentage of CDC funds supporting tribes and recent reductions in CDC support for AIDS/HIV capacity building in Indian country. Additional comments were made about the limited public health infrastructure, which exists in some of the tribes.

During the forum, CDC provided information that an estimated $21 million is currently provided from the agency for Indian initiatives and programs. CDC reports that this amount represents approximately eight tenths of one percent of FY 1999 funds for CDC.

With regard to cutbacks in funding for AIDS/HIV, CDC cites limitations in data to adequately capture the full scope of the AIDS epidemic in Indian country. CDC agrees that more representative data are required to build a more accurate picture of the epidemic among American Indians, and as a result, secure increased programmatic resources. An initiative by CDC's National Center for HIV, STD, and TB Prevention to address surveillance issues related to American Indian populations is an example of the agency's efforts to address this issue to date.

The total dollar amount for HIV capacity building awards from CDC's recent "Program Announcement 00003" was lower than the amount provided by its predecessor program "Program Announcement 305". These programs provide funds for capacity building activities to national and regional minority organizations. CDC reports it was not the intent to reduce funding to American Indian organizations, but that funding decisions were made according to AIDS disease prevalence of racial/ethnic groups across the country. Using disease prevalence rates as one of several criterion represented a change from previous funding criteria decisions. This change in funding criteria was due to several factors including a series of consultations with HIV prevention partners, discussions with the Congressional Black Caucus, analyses of the experiences and success of the HIV prevention community planning process, and CDC's other experiences in funding HIV prevention programs. This redesign focuses funding on communities "hardest hit" by the epidemic.

While the overall direct funding to American Indian organizations was reduced, CDC believes there was no actual reduction in services to the American Indian communities. Since the time of the 00003 funding decrease, CDC through its National Center for Chronic Disease Prevention and Health Promotion, awarded additional funds, approximately $50,000 to the National Native American AIDS Prevention Center for HIV prevention technical capacity building assistance.

A primary obstacle facing CDC and American Indian communities to address this issue is the underreporting of HIV/AIDS cases in American Indian communities, both by health care providers and individuals. In addition, a cultural stigma related to HIV/AIDS remains an obstacle in many Indian communities as well as the lack of a reliable public health infrastructure for disease reporting by tribes.

Key contacts on this issue: Ralph T. Bryan, M.D., Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention, c/o IHS Epi Program, 5300 Homestead Rd. NE, Albuquerque, NM 87110, Tel: 505-248-4226, FAX: 505/248-4393, e-mail: rrb2@cdc.gov; and Staff Liaison: Dean Seneca, Minority Health Specialist, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention MS-D39, 1600 Clifton Rd. NE, Atlanta, GA 30333, Tel: 404-639-7220, FAX: 404-639-7039, email: zkg8@cdc.gov

Issue #4: Increased Access to HHS Funding:

All operating divisions within the Department were asked to respond to the concern by tribes that the whole HHS budget should set-aside at least 1.5% of the total budget for Indian programs and Indian communities, and federal law should be amended to allow for tribes to receive direct funding from programs now limited to state block grants. A variety of responses came back. Detailed responses for each OPIDIV can be found in the matrix of responses compiled for this report.

The IHS, for example, reports 100% of its budget is provided to serve American Indian and Alaska Native communities. Among the other agencies, the proportion of funding allocated to Indian communities varied. SAMHSA allocated 2.3% of its FY 2000 annual funding to Indian oriented programs, well beyond the 1.5% recommended by tribes. Likewise, the Administration on Aging identified 1.9% of its annual budget for Indian programming. AHQR reports that 0.95%, or $1.938 million, of its FY 2000 funding supported Indian related matters. HCFA reports that while it does not have a complete and accurate data on exact percentages, in Fiscal Year 1998 data indicates that approximately 1% of Medicaid beneficiaries and 1% of Medicare vendor payments go to American Indians and Alaska Natives. Overall, HHS estimates that 6% of its discretionary budget went to program which directly target American Indians and Alaska Natives in FY 2000.

Some agencies respond to specific directives in appropriations bills setting aside funds for programs serving Indian communities, such as the Center for Disease Control and Prevention, which spent approximately 0.8% of its budget on Indian programs. Other agencies, such as ACF and AoA and ANAs grants to Native Americans. ACF also operates large grant programs, e.g., operate Indian specific categorical programs, such as the Administration for Native Americans (ANA), the Head Start and Child Care Block Grant program and programs who authorizing statues reseve some funding for Native Americans. Larger authorizations serve targeted populations, which also include Indian and Alaska Natives. Agencies such as the Health Care Financing Administration and the National Institutes of Health incorporate much of their efforts in Indian communities under larger legislative authority. Finally, the Food and Drug Administration does not formulate nor track its budget by population or ethnic group, but by specific functions related to its federal authorization and purpose.

A number of HHS agencies reported potential strategies to ensure that Indian communities have proper access to the funding they administer. These strategies include continuing the tribal consultation process and making specific requests for appropriations increases in upcoming fiscal years.

Key contacts on this issue: Robert G. McSwain, Director, Office of Management Support, Indian Health Service, (301) 443-6290; Yvonne Jackson, AOA Director, Office of American Indian, Alaskan Native and Native Hawaiian Programs (OAIANNHP), 202-619-2713; Alexis Clark, ACF, Budget Analyst, Office of Legislative Affairs and Budget 202-401-4530.; Wendy Perry, AHRQ, Senior Program Analyst, 301-594-7248; Nicholas Burbank, ASMB, Senior Program Analyst, (202) 690-7846; Ralph T. Bryan, M.D., Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention, c/o IHS Epi Program, 5300 Homestead Rd. NE, Albuquerque, NM 87110, Tel: 505-248-4226, FAX: 505-248-4393, e-mail: rrb2@cdc.gov; and Dean Seneca, Minority Health Specialist, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention MS-D39, e-mail: zkg8@cdc.gov; Sue Clain, (HCFA/OL), 202-690-8226; John Ruffin, Ph.D., Director, NIH, Associate Director for Research on Minority Health and Director, Office of Research on Minority Health. Phone: (301) 402-1366; Steve Sawmelle, SAMHSA, Intergovernmental Coordinator, Office of Policy and Program Coordination, (301) 443-0419

Issue #5: Inpatient Alcohol and Substance Abuse Treatment is Too Short

Both the IHS and SAMHSA responded to the concern that federally supported inpatient treatment for alcoholism and substance abuse is too short in duration, and seems to be disconnected to an overall continuum of care, including aftercare.

The IHS cites several statutes which specifically authorize treatment for substance abuse, including the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (PL 99-570); The Anti-Drug Abuse Act of 1988 (PL 100-690; PL 102-573); the Indian Self-Determination Act (PL 93-638) and The Indian Health Care Improvement Act (PL 94-437). The Substance Abuse and Mental Health Services Administration (SAMHSA) cites its authority in this area under 42 USC 290 (aa) and 42 USC 290 (ff).

The IHS references several evaluations of the effectiveness of inpatient adolescent treatment, women's treatment and aftercare/continuing care, which have either been completed or are ongoing. The IHS has undertaken a software and data development for measuring the substance abuse and underage alcohol problems among American Indians and Alaska Natives. The Chemical Dependency Management Information System and the Mental Health/Social Services packages of the IHS RPMS system are now available to all IHS Areas, including tribes and urban programs.

SAMHSA awards competitive grants for substance abuse treatment to communities, including federally recognized tribes. These programs, funded through SAMHSA's Center for Substance Abuse Treatment (CSAT) determine the most effective length of treatment in the design of their own programs and based on the individual needs of clients. SAMHSA's Center for Substance Abuse Treatment (CSAT) will continue to provide grants in the Targeted Capacity Expansion, Exemplary Practices for Adolescents, and Practice/Research Collaborative programs. Such funding, as it relates to AI/AN tribes, will help toward reducing the need for extended residential treatment, including that for tribal youth. Mental health funding is provided to tribes through the Children's Mental Health Initiative and Circles of Care projects funded by the Center for Mental Health Services.

IHS funding for Alcohol and Substance Abuse treatment activities in FY 2000 was $96.824 million and $100.54 million in FY 2001. Support for Mental Health/Social Services during the same years was $43.245 million in FY 2000 and $45.117 million in FY 2001. SAMHSA funding includes the following:

Targeted Capacity Expansion programs
FY00 – $114 million ($29.4 million for AI/AN)
FY01 – $163 million ($29.4 million for AI/AN)
(preliminary figure from Conference Action)

Practice/Research Collaborative
FY00 – $3.1 million ($650,000 for AI/AN)
FY01 – $2.7 million ($400,000 for AI/AN)

Exemplary Practices for Adolescents
FY00 – $4.3 million ($430,000 for AI/AN)
FY01 – $2.2 million ($430,000 for AI/AN)

Child Mental Health Initiative:
FY00 – $82.7 million ($7.2 million for AI/AN)
FY01 – $86. 8 million ($7.2 million for AI/AN)

Circles of Care (AI/AN):
FY00 – $2.4 million
FY01 – $2.4 million

Strategies to address concerns about treatment length and coordination, center on improved coordination among the various federal agencies involved in substance abuse treatment and prevention in Indian country, including the IHS, SAMHSA, BIA and DOJ. Effective programs need a means to share best practices with other communities and funding agencies.

Key contacts on this issue: Craig Vanderwagen, M.D., Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service, (301) 443-4644Steve Sawmelle, Intergovernmental Coordinator, Office of Policy and Program Coordination, (301) 443-0419.

Issue #6: Communication:

In the area of Intergovernmental Relations, the IHS and HHS Office of Intergovernmental Affairs responded to tribal concerns about communication mechanisms. There were recommendations from tribes to look to many of the existing national and regional intertribal organizations, while keeping lines of communication open with each individual, federally recognized tribe.

The IHS and IGA have utilized organizations like the National Indian Health Board, the National Congress of American Indians, the Self-Governance Tribal Advisory Council and the National Council of Urban Indian Health to communicate with Indian country. In addition, individual letters and correspondence is provided to tribal leadership through "Dear Tribal Leader" letters.

The IHS has incorporated into the IHS Area Director's Senior Executive Service Work Plan, the requirement to provide leadership in support to tribal governments, tribal organizations and urban Indian programs. The Area Director is responsible to ensure that tribal consultation is an integral part of HHS/IHS policy development and budget formulation.

Some of the obstacles to improved communication between agencies of HHS and Indian country, is making sure the information is provided on a timely basis through the most appropriate channels. The IGA will continue to work with tribal leaders to ensure that they receive information and invitations for consultation on all major health and human services issues.

Key contacts on this issue: IHS Response: Don Davis, Director of Field Operations, Office of the Director, Indian Health Service, (301) 443-1083, and Phyllis Wolfe, Senior Advisor to the Director of Field Operations, Office of the Director, Indian Health Service, (301) 443-1083; and Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, Office of Intergovernmental Affairs, HHS.

Issue #7: International Borders:

The issue of tribal health programs bearing the burden of treating persons injured or sick while in the custody of the Immigration and Naturalization Service (INS) along the US/Mexico border was raised at both regional and the national meetings.

The IHS cites federal statutes which require treatment of individuals in this situation. The citations include, Emergency Medical Treatment and Labor Act, 42 CFR, Sec. 1395dd., which requires medical screening examination, stabilization, and transfer for all patients requesting emergency care; and Restricting Welfare and Public Benefits for Aliens, 8 USC, Sec. 1611, which states that an unqualified alien is not eligible for any Federal public benefit. Privacy Act, 5 USC, Sec. 552 (a), which for medical records purposes, does not cover Undocumented Aliens.

The IHS proposes to continue submitting billing and cost documentation to the INS for health services related to treating Undocumented Aliens, and continue working with tribes and the INS to formulate policies at the local level, and if necessary elevate these discussions to the national level for resolution. The IHS has already begun discussion

of this sort in the Tucson Area of the IHS, meeting with both the Tohono O'odham Nation, the US Border Patrol and the INS to resolve reimbursement issues.

There are no appropriations provided to serve this population. Because the Border Patrol considers transportation of Undocumented Aliens to IHS facilities "humanitarian rescue", the services provided are non-reimbursable under INS policy. Additional discussion at the national and possibly international level are needed to resolve this problem.

Key contacts on this issue: Taylor Satala, Area Director, Tucson Area Indian Health Service, (520) 295-2405, and George Bearpaw, Executive Officer, Tucson Area Indian Health Service, (520) 295-2402.

Issue #9: Consultation:

Every HHS OPDIV was asked to respond to tribal concerns about the consultation process and how individual consultation plans were to be implemented and monitored.

While the IHS implemented its consultation policy in 1997, the rest of the HHS agencies based their consultation plans upon the Presidential Executive Order #13084, of May 14, 1998, which directed Federal agencies to establish regular and meaningful consultation and collaboration with Indian tribal governments and on the Secretary's consultation policy in August 1997, directing each agency to develop an individualized consultation plan. These plans were printed and disseminated to every tribe in the United States asking for review and comments. Several agencies such as ACF, also posted their consultation plan on the web. Only a small number of tribal comments came back to the agencies regarding these plans.

Several agencies have initiated consultation meetings or councils, such as the Administration on Aging, Centers for Disease Control and Prevention, ACF, HCFA, NIH, and IHS. All HHS agencies have participated with tribes and national Indian organizations in the budget formulation process. Each agency has described efforts to improve and expand tribal consultation.

Key contacts on this issue: Sharon McCully, ANA/ACF, Executive Director Intra-departmental Council on Native American Affairs (202) 690-5780; Douglas Black, Director, Office of Tribal Programs, Office of the Director, Indian Health Service, (301) 443-1104; Wendy Perry, AHRQ, Senior Program Analyst, 301-594-7248; Yvonne Jackson, AOA, Director, OAIANNHP, 202-619-2713; Ralph T. Bryan, M.D., Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention, c/o IHS Epi Program, 5300 Homestead Rd. NE, Albuquerque, NM 87110, Tel: 505-248-4226, FAX: 505 248-4393, e-mail: rrb2@cdc.gov; and Staff Liaison: Dean Seneca, Minority Health Specialist, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention, MS-D39, 1600 Clifton Rd. NE, Atlanta, GA 30333, Tel: 404-639-7220, FAX: 404-639-7039, email: zkg8@cdc.gov; Linda Brown, (HCFA) Technical Director, (202)-690-6257; John Ruffin, Ph.D, Director, Associate Director for

Research on Minority Health and Director, NIH, Office of Research on Minority Health. Phone: (301) 402-1366; Steve Sawmelle, SAMHSA, Intergovernmental Coordinator, Office of Policy and, Program Coordination, (301) 443-0419

Issue #10: State Resistance

There was concern voiced by tribes and national Indian organizations regarding some states which resist or even refuse to cooperate with tribes in areas of mutual concern. A specific example was referenced dealing with the state of South Dakota's moratorium on the use of Medicaid dollars to support new nursing homes in the state. This issue involves not just the state and the tribes wanting to build nursing homes, but also HCFA, IGA and potentially the Office for Civil Rights (OCR).

The OCR reports that the issue in South Dakota is being addressed on several levels. The Governor for South Dakota formed a Workgroup to address the problem, which includes the participation of HCFA, BIA, IHS, State Medicaid staff and Indian tribes. The issue addressed by the Governor's Workgroup is "access" to nursing home services. Without the cooperation of the State, new tribal nursing homes cannot rely on Medicaid revenues for eligible patients. Currently there is no legal authority for HCFA to pass along 100% of the federal Medicaid dollars to tribally operated nursing homes, without going through the state. In 1999, the State of South Dakota legislature extended the moratorium on nursing homes for another five (5) years. Provisions in the draft bill to reauthorize the Indian Health Care Improvement Act would allow for direct Medicaid funding for tribal nursing homes, but that legislation has not been enacted.

Addressing tribal concerns on a more national basis, HCFA has prepared a draft letter to the State Medicaid Directors and to Tribal leaders informing them that once the letters are issued, the states will have to consult with all Federally recognized tribes in their state on Section 1115 Medicaid managed care demonstration waivers, Section 1915(b) freedom of choice waivers, and Section 1915(c) home and community based services waivers prior to submission of the proposal to HCFA.

Key contacts on this issue: Nancy Goetschius, (HCFA) Health Insurance Specialist, (410) 786-0707; Cindy Myers, OCR, State Program Coordinator, 303-844-7116; Kathleen O'Brien, OCR, 202-219-2829.

Issue #11: Community-based Research

Tribes expressed concern about research and the need to funnel all research targeting Indian populations through the appropriate tribal or Indian community Institutional Review Board (IRB). Tribes were also concerned about the government's reliance upon universities to conduct research, instead of placing a premium on community based approaches. There are four agencies which responded to this concern for community-based research. They are AHRQ, CDC, NIH and SAMHSA.

SAMHSA is implementing community-based research through competitive grant-making for "Knowledge Development and Application" projects, including the Circles of Care projects funded in Indian communities. In these situations, it is the responsibility of the grantee to go through tribal Institutional Review Boards.

The AHRQ and CDC propose to continue working with tribes to forge partnerships between tribes and academic institutions and to build research infrastructure at the local level. AHRQ has many training programs which can assist in the development tribal research infrastructure, available through its website. AHRQ awarded a major grant to an Indian-based consortium to perform research on health care disparities among the Indian elderly and has funded a planning grant to an Indian-focused primary care practice-based research network. In FY 2000 a large program project grant was awarded to the University of Colorado to research health care disparities among Indian elderly. Another large grant was made to the University of New Mexico to look at diabetes care among the Navajo. A planning grant, funded by the IHS was awarded to a primary-care based research network to develop a plan for a network of office-based primary care practices dedicated to research.

CDC works closely with the Indian IRB's, and the IHS-based human subjects review boards and has assisted a tribe in the development of its own IRB, and seeks tribal partnerships in its research activities involving American Indian and Alaska Native participants.

NIH traditionally requires a university environment or setting because of the types of technology and other types of resources that are required. NIH is committed to designing programs that will provide opportunities for Tribal Colleges and Universities (TCU) and tribal community partnerships. One such effort in the NIH Center for Research on Minority Health and Health Disparities is the proposed Office for Community Based Research and Outreach. A total of $197 million is anticipated in Fiscal Year 2001 to support this new effort, if the Center is authorized. This center will develop state and local research programs related to health disparities and minority health. This new office will be key in increasing tribal involvement in Indian health research.

Some of the obstacles to community-based research in Indian country, are the limited number of conduits for building research infrastructure within Indian communities. There are a limited number of tribal IRBs. However, there are opportunities to expand research through the use of tribal colleges and universities and by developing tribal research infrastructure. Training of more American Indian and Alaska Native researchers is essential.

Key contacts on this issue: Wendy Perry, AHRQ, Senior Program Analyst, 301-594-7248
Ralph T. Bryan, M.D., Senior CDC/ATSDR Tribal Liaison, Office of The Associate Director for Minority Health, Centers for Disease Control and Prevention, c/o IHS Epi Program, 5300 Homestead Rd. NE, Albuquerque, NM 87110, Tel: 505-248-4226, FAX: 505 248-4393, e-mail: rrb2@cdc.gov; and Staff Liaison:Dean Seneca, Minority Health Specialist Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention MS-D39, 1600 Clifton Rd. NE, Atlanta, GA 30333, Tel: 404-639-7220, FAX: 404-639-7039 e-mail: zkg8@cdc.gov; John Ruffin, Ph.D., Director, Associate Director for Research on Minority Health and Director, NIH, Office of Research on Minority Health. Phone: (301) 402-1366; Steve Sawmelle, SAMHSA, Intergovernmental Coordinator, Office of Policy and Program Coordination, (301) 443-0419.

Chapter IV – Next Steps

The Department of Health and Human Services and tribal governments have developed a sound foundation for meaningful dialogue through the consultation processæour journey, however, has only begun. Together, we have discussed issues and explored ways to address them and are now moving toward implementing a number of recommendations. This report captures the recommendations by tribal leaders and HHS agencies.

To ensure that we move forward, the following critical steps were identified:

Establish a Single Point of Contact in the Department

A key step in assuring that the momentum in our work is maintained was to create and fill a senior level position in the Office of the Secretary focused solely on tribal issues. With the participation of tribal leadership, the Senior Advisor for Tribal Affairs has been selected and will work within the Office of Intergovernmental Affairs. This individual serves as the Department's point person on issues pertinent to American Indians and Alaska Natives (AI/AN) and will: coordinate HHS efforts to address AI/AN concerns, including those identified in this report; monitor the Department's tribal consultation process; and, assist tribes in navigating through HHS programs and services.

Maintain and Enhance the Consultation Process

Intergovernmental relations and tribal consultation ranked among the most important issues raised by tribal leaders at the regional and national meetings. Tribal leaders pointed out the need for continued dialogue and a strengthened consultation process. HHS agencies have refined their consultation plans and are beginning to build on the recommendations by tribal leaders. We intend to continue to consult on HHS budgets and engage in national consultation meetings.

In addition to enhancing the consultation process, the Department is obligated to improve its communication with tribal governments to the greatest extent practicable. HHS recognizes the difficulty in consulting directly with every tribe on the vast number of policy matters that could potentially affect them. Tribal leaders provided a number of recommendations to improve existing communications, including that the Department utilize national Indian organizatons to get the message out to Indian country. In response, the Department has requested that tribes specifically consider designating representatives who would regularly consult with HHS, disseminate information to the tribes they are representing, and provide immediate feedback and input to HHS on policies, programs, and budgets. We encourage additional thoughts as to how HHS can implement a more efficient commu-

nication process to enhance tribal consultation. Executive Order 13175 which was signed on November 6, 2000 and becomes effective on January 6, 2001, further prescribes how the Department will consult with tribal governments on actions that affect them.

Develop the Scope and Conduct of the Tribal Self-Governance Feasibility Study

HHS is implementing the Tribal Self-Governance Amendments of 2000 [PL.106-260], which, among other things, requires the Secretary to conduct a study to determine the feasibility of a demonstration project that would extend tribal self-governance to HHS programs other than those in the Indian Health Service. The Department must submit a report that provides analysis and recommendations concerning the feasibility of the demonstration to Congress by February 2002. Tribal leaders are currently working with HHS in developing the protocol for the consultation necessary to conduct the study. Tribes will be able to submit their separate views as a part of the Secretary's Report to Congress.

Joint Tribal/Federal Negotiated Rulemaking Committee for the Development of Regulations for the Tribal Self-Governance Program.

HHS published a notice in the Federal Register in December 2000 inviting comments on the HHS intent to establish a Joint Tribal/Federal Negotiated Rulemaking Committee pursuant to statutory requirements under P.L. 106-260, the Self-Governance Amendments of 2000. HHS has identified the federal representatives who will participate in the Committee process. The statute requires that proposed rules be published within one year of enactment (August 18, 2001), and that final rules be promulgated within 21 months of enactment. The HHS Staff divisions identified to participate are the Assistant Secretary for Management and Budget, Office of General Counsel, and the Office of Intergovernmental Affairs. The IHS has also identified agency representatives for the Committee.

Implement Actions to Address Regional and National Issues

Issues and recommendations identified at the regional and national meetings have been addressed by HHS agencies and steps taken by HHS agencies are included in the matrix found in the Appendix to this report. In some cases, issues are clearly resolved, while others require additional dialogue.

This report should not be considered final. It is both a marker of where we are at this time and a record of how our continuing dialogue with AI/ANs has reached this point. We actively solicit your comments on the HHS responses to the regional and national issues raised, next steps proposed in this chapter, and new issues that you believe warrant HHS action.

Consultation with American Indians and Alaska Natives

A Report on the Continuing Dialogue Between the Department of Health and Human Services and American Indian and Alaska Native Leaders

Appendices

APPENDIX 1

U.S. Department of Health and Human Services – a Description

The U.S. Department of Health and Human Services is the United States Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The Department includes more than 300 programs, covering a wide spectrum of activities, and is the largest grant-making agency in the federal government, providing some 60,000 grants per year. Some highlights include:

- Medical and social science research
- Preventing outbreak of infectious disease, including immunization services
- Assuring food and drug safety
- Medicare (health insurance for elderly and disabled Americans) and Medicaid (health insurance for low-income people)
- Financial assistance for low-income families
- Child support enforcement
- Improving maternal and infant health
- Head Start (pre-school education and services)
- Preventing child abuse and domestic violence
- Substance abuse treatment and prevention
- Services for older Americans, including home-delivered meals
- Comprehensive health services delivery for American Indians and Alaska Natives

HHS works closely with state, local and tribal governments, and many HHS-funded services are provided at the local level by state, county or tribal entities, or through private sector grantees.

A. The Staff Divisions

The Office of the Secretary is comprised of the following staff divisions:

<u>Office of Public Health and Science (OPHS)</u>
The Office of Public Health and Science (OPHS) is under the direction of the Assistant Secretary for Health, who serves as the Secretary's senior advisor on public health and science issues. OPHS serves as the focal point for leadership and coordination across the Department in public health and science; provides direction to program offices within OPHS; and provides advice and counsel on public health and science issues to the Secretary.

<u>Office of the Assistant Secretary for Management and Budget (ASMB)</u>
The Office of the Assistant Secretary for Management and Budget (ASMB) provides the highest quality advice and service in administrative and financial management to the Secretary and all the Department of Health and Human Services components.

Office of Assistant Secretary for Planning and Evaluation (ASPE)
The Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary on policy development and is responsible for major activities in the areas of policy coordination, legislation development, strategic planning, policy research and evaluation, and economic analysis.

Office of Civil Rights (OCR)
The Office for Civil Rights (OCR) ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination. Through prevention and elimination of unlawful discrimination, OCR helps HHS carry out its overall mission of improving the health and well-being of all people affected by its many programs.

Office of Intergovernmental Affairs (IGA)
The Office of Intergovernmental Affairs (IGA) facilitates communication regarding HHS initiatives as they relate to state, local, and tribal governments. IGA serves the dual role of representing the state, local and tribal governmental perspective in the federal policymaking process as well as clarifying the federal perspective to state, local, and tribal governmental representatives. IGA works directly with the states and tribes, as well as with the national intergovernmental organizations representing them.

The Office of the Assistant Secretary for Legislation (ASL)
The Office of the Assistant Secretary for Legislation (ASL) provides advice to the Secretary on congressional legislation and facilitates communication between the Department and Congress. ASL is responsible for the development and implementation of the Department's legislative agenda and is the liaison with members of Congress and their staffs. The Office informs the Congress of departmental priorities, actions, grants and contracts.

B. The Operating Divisions

The Department's programs are administered by 11 HHS operating divisions. They are as follows:

Administration on Aging (AoA)
The Administration on Aging (AoA) is the federal focal point and advocate agency for older persons and their concerns. The AoA administers key Federal programs mandated under various titles of the Older Americans Act. These programs help vulnerable older persons remain in their own homes by providing supportive services, including nutrition programs like home delivered (meals on wheels) meals. Other programs offer opportunities for older Americans to enhance their health and to be active contributors to their families, communities, and the Nation. The AoA works closely with its nationwide network of regional offices and State and Area Agencies on Aging to plan, coordinate, and develop community-level systems of services that meet the unique needs of individual older persons and their caregivers. The AoA collaborates with Federal agencies, national organizations, and representatives of business to ensure that, whenever possible, their programs and resources are targeted to older persons and coordinated with those of the network on aging.

This role leads to two essential tasks. One is to serve well the 43 million seniors through the objectives and programs of Older Americans Act. The second is to plan ahead for the doubling of that population by bringing to bear the resources of this Department and the Administration.

Administration for Children and Families (ACF)

The Administration for Children and Families (ACF) is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. ACF is responsible for some 60 programs that promote the economic and social well-being of families, children, individuals and communities. It administers the state-federal welfare program, Temporary Assistance to Needy Families, providing assistance to an estimated 7.3 million persons, including 6.3 million children in September 1998. It also administers national child support enforcement system, collecting some $15.5 billion in FY 1999 in payments from non-custodial parents and the Head Start program, serving more than 800,000 pre-school children. Additionally, ACF provides funds to assist low-income families in paying for child care, supports state programs to provide for foster care and adoption assistance, and funds programs to prevent child abuse and domestic violence.

Agency for Healthcare & Quality (AHRQ)

The Agency for Healthcare Research and Quality (AHRQ) was established in 1989 as the Agency for Health Care Policy and Research. Reauthorizing legislation passed in November 1999 establishes AHRQ as the lead federal agency on quality research and is charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essential services. AHRQ's broad programs of research bring practical, science-based information to medical practitioners and to consumers and other health care purchasers.

Agency for Toxic Substances and Disease Registry (ATSDR)

The mission of the Agency for Toxic Substances and Disease Registry (ATSDR) is to prevent exposure and adverse human health effects and diminished quality of life associated with exposure to hazardous substances from waste sites, unplanned releases, and other sources of po9llution present in the environment. ATSDR is directed by congressional mandate to perform specific functions concerning the effect on public health of hazardous substances in the environment. These functions include public health assessments of waste sites, health consultations concerning specific hazardous substances, applied research in support of public health assessments, information development and dissemination, and education and training concerning hazardous substances.

Centers for Disease Control and Prevention (CDC)

The Centers for Disease Control and Prevention (CDC) is the lead federal agency responsible for protecting the health of the American public through monitoring of disease trends, investigation of outbreaks, health and injury risks, foster a safe and healthful environments, and implementation of illness and injury control and prevention interventions.

Food and Drug Administration (FDA)

The Food and Drug Administration touches the lives of virtually every American every day. It ensures that the food we eat is safe and wholesome, the cosmetics we use won't harm us, the medicines and medical devices we use are safe and effective, and that radiation-emitting products such as microwave ovens won't do us harm. Feed and drugs for pets and farm animals also come under FDA scrutiny. FDA also ensures that all of these products are labeled truthfully with the information that people need to use them properly.

Health Care Financing Administration (HCFA)

The Health Care Financing Administration (HCFA) administers the Medicare and Medicaid programs—two national health care programs that benefit about 75 million Americans. And with the Health Resources and Services Administration, HCFA runs the State Children's Health Insurance Program, a program that is expected to cover many of the approximately 10 million uninsured children in the United States.

HCFA also regulates all laboratory testing (except research) performed on humans in the United States. Approximately 158,000 laboratory entities fall within HCFA's regulatory responsibility. And HCFA, with the Departments of Labor and Treasury, helps millions of Americans and small companies get and keep health insurance coverage and helps eliminate discrimination based on health status for people buying health insurance.

Health Resources and Service Administration (HRSA)

The Health Resources and Services Administration (HRSA) directs national health programs that improve the nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV/AIDS, provides primary health care to medically underserved people, serves women and children through state programs, and trains a health workforce that is both diverse and motivated to work in underserved communities.

Indian Health Service (IHS)

The Indian Health Service (IHS) is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders.

IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people. IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 550 federally recognized tribes in 35 states.

National Institutes of Health (NIH)
NIH's mission is to uncover new knowledge that will lead to better health for everyone. NIH works toward that mission by: conducting research in its own laboratories; supporting the research of non-Federal scientists in universities, medical schools, hospitals, and research institutions throughout the country and abroad; helping in the training of research investigators; and fostering communication of medical information.

Program Support Center (PSC)
The mission of the Program Support Center (PSC) is to provide qualitative and responsive "support services" on a cost-effective, competitive, "service-for-fee" basis to HHS components and other federal organizations and agencies. This distinctive, self-supporting operation brings a pioneering business-like enterprise approach to government support services. PSC's objective is to enhance the productivity, quality and responsiveness of governmental organizations with administrative support service responsibilities.

Substance Abuse and Mental Health Services Administration (SAMHSA)
The Substance Abuse and Mental Health Services Administration (SAMHSA) is charged with improving the quality and availability of prevention, treatment, and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

APPENDIX 2

Title 3--
The President

Executive Order 13175 of November 6, 2000

Consultation and Coordination With Indian Tribal Governments

By the authority vested in me as President by the Constitution and the laws of the United States of America, and in order to establish regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have tribal implications, to strengthen the United States government-to-government relationships with Indian tribes, and to reduce the imposition of unfunded mandates upon Indian tribes; it is hereby ordered as follows:

Section 1. Definitions. For purposes of this order:

(a) ``Policies that have tribal implications'' refers to regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effects on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

(b) ``Indian tribe'' means an Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a.

(c) ``Agency'' means any authority of the United States that is an ``agency'' under 44 U.S.C. 3502(1), other than those considered to be independent regulatory agencies, as defined in 44 U.S.C. 3502(5).

(d) ``Tribal officials'' means elected or duly appointed officials of Indian tribal governments or authorized intertribal organizations.

Sec. 2. Fundamental Principles. In formulating or implementing policies that have tribal implications, agencies shall be guided by the following fundamental

principles:

(a) The United States has a unique legal relationship with Indian tribal governments as set forth in the Constitution of the United States, treaties, statutes, Executive Orders, and court decisions. Since the formation of the Union, the United States has recognized Indian tribes as domestic dependent nations under its protection. The Federal Government has enacted numerous statutes and promulgated numerous regulations that establish and define a trust relationship with Indian tribes.

(b) Our Nation, under the law of the United States, in accordance with treaties, statutes, Executive Orders, and judicial decisions, has recognized the right of Indian tribes to self-government. As domestic dependent nations, Indian tribes exercise inherent sovereign powers over their members and territory. The United States continues to work with Indian tribes on a government-to-government basis to address issues concerning Indian tribal self-government, tribal trust resources, and Indian tribal treaty and other rights.

(c) The United States recognizes the right of Indian tribes to self-government and supports tribal sovereignty and self-determination.

Sec. 3. Policymaking Criteria. In addition to adhering to the fundamental principles set forth in section 2, agencies shall adhere, to the extent permitted by law, to the following criteria when formulating and implementing policies that have tribal implications:

(a) Agencies shall respect Indian tribal self-government and sovereignty, honor tribal treaty and other rights, and strive to meet the responsibilities that arise from the unique legal relationship between the Federal Government and Indian tribal governments.

(b) With respect to Federal statutes and regulations administered by Indian tribal governments, the Federal Government shall grant Indian tribal governments the maximum administrative discretion possible.

(c) When undertaking to formulate and implement policies that have tribal implications, agencies shall:

(1) encourage Indian tribes to develop their own policies to achieve program objectives;

(2) where possible, defer to Indian tribes to establish standards; and

(3) in determining whether to establish Federal standards, consult with tribal officials as to the need for Federal standards and any alternatives that would limit the scope of Federal standards or otherwise preserve the prerogatives and authority of Indian tribes.

Sec. 4. Special Requirements for Legislative Proposals. Agencies shall not submit to the Congress legislation that would be inconsistent with the policymaking criteria in Section 3.

Sec. 5. Consultation. (a) Each agency shall have an accountable process to ensure meaningful and timely input by tribal officials in the development of regulatory policies that have tribal implications. Within 30 days after the effective date of this order, the head of each agency shall designate an official with principal responsibility for the agency's implementation of this order. Within 60 days of the effective date of this order, the designated official shall submit to the Office of Management and Budget (OMB) a description of the agency's consultation process.

(b) To the extent practicable and permitted by law, no agency shall promulgate any regulation that has tribal implications, that imposes substantial direct compliance costs on Indian tribal governments, and that is not required by statute, unless:

(1) funds necessary to pay the direct costs incurred by the Indian tribal government or the tribe in complying with the regulation are provided by the Federal Government; or

(2) the agency, prior to the formal promulgation of the regulation,

(A) consulted with tribal officials early in the process of developing the proposed regulation;

(B) in a separately identified portion of the preamble to the regulation as it is to be issued in the Federal Register, provides to the Director of OMB a tribal summary impact statement, which consists of a description of the extent of the agency's prior consultation with tribal officials, a summary of the nature of their concerns and the agency's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of tribal officials have been met; and

(C) makes available to the Director of OMB any written communications submitted to the agency by tribal officials.

(c) To the extent practicable and permitted by law, no agency shall promulgate any regulation that has tribal implications and that preempts tribal law unless the agency, prior to the formal promulgation of the regulation,

(1) consulted with tribal officials early in the process of developing the proposed regulation;

(2) in a separately identified portion of the preamble to the regulation as it is to be issued in the Federal Register, provides to the Director of OMB a tribal summary impact statement, which consists of a description of the extent of the agency's prior consultation with tribal officials, a summary of the nature of their concerns and the agency's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of tribal officials have been met; and

(3) makes available to the Director of OMB any written communications submitted to the agency by tribal officials.

(d) On issues relating to tribal self-government, tribal trust resources, or Indian tribal treaty and other rights, each agency should explore and, where appropriate, use consensual mechanisms for developing regulations, including negotiated rulemaking.

Sec. 6. Increasing Flexibility for Indian Tribal Waivers.

(a) Agencies shall review the processes under which Indian tribes apply for waivers of statutory and regulatory requirements and take appropriate steps to streamline those processes.

(b) Each agency shall, to the extent practicable and permitted by law, consider any application by an Indian tribe for a waiver of statutory or regulatory requirements in connection with any program administered by the agency with a general view toward increasing opportunities for utilizing flexible policy approaches at the Indian tribal level in cases in which the proposed waiver is consistent with the applicable Federal policy objectives and is otherwise appropriate.

(c) Each agency shall, to the extent practicable and permitted by law, render a decision upon a complete application for a waiver within 120 days of receipt of such application by the agency, or as otherwise provided by law or regulation. If the application for waiver is not granted, the agency shall provide the applicant with timely written notice of the decision and the reasons therefor.

(d) This section applies only to statutory or regulatory requirements that are discretionary and subject to waiver by the agency.

Sec. 7. Accountability.

(a) In transmitting any draft final regulation that

has tribal implications to OMB pursuant to Executive Order 12866 of September 30, 1993, each agency shall include a certification from the official designated to ensure compliance with this order stating that the requirements of this order have been met in a meaningful and timely manner.

(b) In transmitting proposed legislation that has tribal implications to OMB, each agency shall include a certification from the official designated to ensure compliance with this order that all relevant requirements of this order have been met.

(c) Within 180 days after the effective date of this order the Director of OMB and the Assistant to the President for Intergovernmental Affairs shall confer with tribal officials to ensure that this order is being properly and effectively implemented.

Sec. 8. Independent Agencies. Independent regulatory agencies are encouraged to comply with the provisions of this order.

Sec. 9. General Provisions. (a) This order shall supplement but not supersede the requirements contained in Executive Order 12866 (Regulatory Planning and Review), Executive Order 12988 (Civil Justice Reform), OMB Circular A-19, and the Executive Memorandum of April 29, 1994, on Government-to-Government Relations with Native American Tribal Governments.

(b) This order shall complement the consultation and waiver provisions in sections 6 and 7 of Executive Order 13132 (Federalism).

(c) Executive Order 13084 (Consultation and Coordination with Indian Tribal Governments) is revoked at the time this order takes effect.

(d) This order shall be effective 60 days after the date of this order.

Sec. 10. Judicial Review. This order is intended only to improve the internal management of the executive branch, and is not intended to create any right, benefit, or trust responsibility, substantive or procedural, enforceable at law by a party against the United States, its agencies, or any person.

THE WHITE HOUSE,

November 6, 2000.

APPENDIX 3

TRIBAL CONSULTATION PLAN
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary – Staff Divisions

1. INTRODUCTION

The United States (U.S.) government and the governments of American Indians and Alaska Natives (AI/AN or Indian people) have a unique government-to-government relationship based on the U.S. constitution, treaties, Federal statutes, court decisions, and executive branch policies, as well as moral and ethical considerations. Increasingly this special relationship has emphasized self-determination for Indian people and meaningful involvement by Indian people in federal decision-making (consultation) where such decisions affect Indian people, either because of their status as Indian people or otherwise.

Consistent with these principals, the President issued an Executive Memorandum on April 29, 1994, titled, "Government-to-Government Relationship with Native American Tribal Governments." This Memorandum states that in all activities relating to or affecting the government or treaty rights of Indian tribes, the executive branch shall:

a. operate within a government-to-government relationship with federally recognized Indian tribes;

b. consult, to the greatest extent practicable and permitted by law, with Indian tribal governments before taking actions that affect federally recognized Indian tribes;

c. assess the impact of agency activities on tribal trust resources and assure that tribal interests are considered before the activities are undertaken;

d. remove procedural impediments to working directly with tribal governments on activities that affect trust property or governmental rights of the tribes; and

e. work cooperatively with other agencies to accomplish these goals established by the President.

The President issued Executive Order 13084, dated May 14, 1998 and titled "Consultation and Coordination with Indian Tribal Governments", to establish regular and meaningful consultation and collaboration with Indian tribal governments:

a. In the development of regulatory practices on Federal matters that significantly or uniquely affect their communities;

b. To reduce the imposition of unfunded mandates upon Indian tribal governments; and
c. To streamline the application process for and increase the availability of waivers to Indian tribal governments.

On August 7, 1997, U.S. Department of Health and Human Services (HHS) Secretary Donna E. Shalala issued a memorandum establishing the HHS policy on consultation with American Indian/Alaska

Native (AI/AN) Tribes and Indian organizations. In addition to establishing HHS wide policy, this memorandum directed each agency to develop their own individualized consultation plan consistent with HHS policy.

On November 6, 2000, President Clinton issued his final directive from the White House regarding tribal consultation, Executive Order 13175, titled "Consultation and Coordination with Indian Tribal Governments." EO 13175, which mirrors the Administration's Federalism Executive Order pertaining to state and local governments, requires all departments and agencies to consult with tribes as they develop policy on issues that have tribal implications. This latest Executive Order expands the criteria to be met when formulating and implementing policies that have tribal implications. It also requires that each agency select an official with principal responsibility for the implementation of this order. Compliance with the EO will be monitored by Executive Secretariat to the Department.

Consultation examples include:

a. Departmental regulations implementing the Indian Self-Determination Act, as amended, such as: "It is the policy of the Secretary to facilitate the effort of Indian tribes and tribal organizations to plan, conduct, and administer programs, functions, services and activities, or portions thereof, which the departments are authorized to administer for the benefit of Indians because of their status as Indians..."

b. Federal laws such as the Unfunded Mandates reform Act of 1995, P.L.104-4, which states: "The purposes of this Act are...to assist Federal agencies in their consideration of proposed regulations affecting...Tribal governments by...requiring that Federal agencies develop a process to enable...Tribal governments to provide input when Federal agencies are developing regulations, and requiring that Federal agencies prepare and consider the budgetary impact of Federal regulations containing Federal mandates upon...Tribal governments before adopting such regulations (Sec.2)."

2. PURPOSE

To establish an Office of the Secretary (OS) Staff Division (STAFFDIV) policy on consultation with AI/AN tribal governments; reaffirm the STAFFDIV recognition of the sovereign status of federally recognized Indian tribes; to reaffirm adherence to the principles of government-to-government relations; to inform Staff division personnel, other federal agencies, federally recognized Indian tribes, Indian organizations, and the public of the STAFFDIV working relationships with federally recognized Indian tribes.

3. DEFINITION

Consultation: Consultation is an enhanced form of communication that emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties that leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making.

4. STAFFDIV PARTICIPATION IN DEPARTMENT ACTIONS

HHS OS STAFFDIVs share numerous common characteristics. Their similar missions, goals, operations, and resources are distinct from those of the Department's Operating Divisions (OPDIVs). Based on the shared characteristics of the STAFF/DIVs, and their distinction from the OPDIVs, the Tribal Consultation Working Group requested that the STAFFDIVs develop an integrated response to the initiative.

The STAFFDIVs are responsible for administration, policy development and analysis, budget recommendations and justification, information management, intergovernmental relations, monitoring of program quality, prevention and detection of fraud, waste, and abuse, and other personnel intensive activities for the entire Department. In general, OS STAFFDIVs have no direct responsibilities for grant making, health or social services delivery, or related program activities.

Consistent with the HHS policy, STAFFDIVs will maintain a list of suggested AI/AN participants to attend consultation meetings or subject matter/expert roundtables or forums convened for the department.

The OS will coordinate with other agencies in determining other issues or priorities for legislation or cross cutting initiatives that require department level consultation.

The OS designated single point of contact for program information and assistance will be the Senior Advisor on American Indian and Alaskan Native Affairs, in the Office of Intergovernmental Affairs (OIGA).

5. OS LEVEL ACTIONS

a. With advice and consultation from tribal governments, OIGA will work with the STAFFDIVs to identify critical events at which tribal consultation and participation will be required. This will be accomplished within 120 days of approval of this plan.

   Although the principal focus for consultation and participation activities of OS is with individual tribal governments, it is important that OS solicit advice and involvement from nation Indian organizations and other AI/AN organizations interested in issues affecting AI/ANs.

   Focus group sessions will be held to solicit official tribal comments and recommendations on legislation and budget matters affecting AI/ANs. Issue sessions at roundtables, forums, and meetings will provide the opportunity for meaningful and effective participation by AI/AN officials and organizations in the planning of the OS functions and services.

   The Government Performance and Results Act (GPRA) is intended to help Federal programs succeed by identifying what constitutes successful program performance, what resources are needed and what challenges exist which affect achieving success. GPRA also requires accountability. Consultation with AI/AN will assure that the OS functions achieve success.

b. OIGA will coordinate with OPDIVs to assist states in developing mechanisms for consultation with their AI/AN governments and Indian organizations before taking any actions that affect these governments and/or Indian people. States will receive assistance in developing state plan assurances for the delivery of services to AIs/ANs.

State consultation with AI/AN should be done in a meaningful manner that is consistent with the definition of "consultation" as defined in this policy plan.

OIGA will assure that State plans on consultation with AI/AN are successful by convening conferences with States, AI/AN tribes and organizations, to develop a set of consultation protocols. The developed protocols will be used in the evaluation of States efforts to consult with AI/AN governments and organizations. Technical assistance and monitoring will be provided by Regional Office staff.

Specific mechanisms that will be used to consult with tribal governments are: mailings, meetings, teleconferences, and roundtables.

c. The Assistant Secretary for Management and Budget (ASMB) and the OIGA have established an annual Department-wide budget consultation meeting to bring tribal representatives together with HHS policy officials providing these representatives with an opportunity to present their appropriation priorities. These meetings have taken place in the Spring, before the OPDIVs and STAFFDIVs submit their budget requests to the Department.

d. The OIGA upon completion of a consultation will determine if there are any unresolved issues that would benefit from ongoing involvement of AI/AN tribal governments in implementation and evaluation. The OIGA will include a mechanism to address this need.

e. The OIGA will consult with AI/AN leaders on the "reviewed" policy/plan to provide for effective and meaningful participation by AI/AN.

f. The single point of contact within the OIGA for tribal governments and other Indian people, at a level with access to all OPDIVs/STAFFDIVs, is the Senior Advisor on American Indian and Alaska Native Affairs. This office will serve as the department's point of contact in accessing department-wide information.

g. The HHS consultation policy and implementation plans will be posted on the HHS website homepage, appropriate American Indian websites, and published in the Federal Register soliciting comments. Tribes will be given access to HHS consultation with sufficient time to respond before any final decisions are made.

h. The OIGA will continue to inform tribal leaders on consultation policy by holding meetings, roundtables, teleconferences, forums, and placing information on the HHS website homepage and other appropriate websites.

SUMMARY:

The OIGA considers consultation an evolving process. The HHS' central and regional offices have established relationships with Tribal governments and Indian organizations with which they communicate about HHS programs. This joint partnership will ensure implementation of the consultation plan, allow recommendations for revisions based on periodic assessments, and assure that Tribal issues are promptly addressed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR CHILDREN AND FAMILIES

Policy and Plan
for
Native American Consultation

I. Purpose

The Administration for Children and Families (ACF), as an Operating Division within the Department of Health and Human Services, hereby establishes a Native American consultation policy/plan with American Indian Tribes, Alaska Native villages and Native American organizations, including Native Hawaiian and Native American Pacific Islanders. Where appropriate, ACF will also consult with other eligible Native American entities such as urban Indian centers; tribally controlled community colleges; Alaska Native Regional Corporations and others as defined in program guidance. This policy is a living document that encourages ongoing comments from Indian Country and the Native American community. It was developed based upon:

- Input of all programs within ACF, many of which already consult with Tribes and Native American communities/organizations.

- Input from Tribes and communities to ensure a consultation policy that reflects the goals of all partners involved.

As recommended in Secretary Shalala's memorandum of August 7, 1997 to the heads of Operating Divisions and Staff Divisions, the guidelines provided by the HHS Working Group on Consultation with American Indians and Alaska Natives serve as the framework for the ACF Policy and Plan.

II. Background

A unique, government-to-government relationship exists between the U.S. government and federally recognized Tribes and Alaska Native villages. This relationship is based on the Constitution, treaties, statutes, court decisions and Executive Branch policies, as well as moral and ethical considerations. Certain benefits provided to Indian people through legislatively enacted federal programs are based on this trust relationship. Other statutes and policies exist that provide the foundation for consultation with non-federally recognized Tribes and Native American organizations.

On April 29, 1994 President Clinton affirmed this government-to-government relationship and called on all government agencies to consult with Tribes. As a result, the Domestic Policy Council's Working Group on Indian Affairs, chaired by Secretary Babbitt, requested a consultation policy and plan from each Department. A HHS Tribal Consultation Workgroup, representative of all OPDIVs/STAFFDIVS, was tasked with developing the Department policy and plan. On August 7, 1997, Secretary Shalala signed the HHS official policy, designating the Office of Intergovernmental Affairs (IGA) as point of contact for tribal consultation. She also requested that each OPDIV/STAFFDIV develop its own, individualized plan consistent with the Workgroup report.

III. Foundations

Support for Native American consultation is based primarily on the following considerations:

Political and legal:

- References to tribal consultation can be found in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, Sections 3(a) and 3(b) as amended; the Indian Health Care Improvement Act, P.L. 94-437, Section 2(b), as amended; and the unfunded Mandates Reform Act of 1995, P.L. 104-4.

- In his April 29, 1994 Executive Memorandum to the heads of federal agencies, President Clinton reaffirmed the government-to-government relationship between Indian Tribes and the federal government, and directed each executive department and agency to consult with tribal governments prior to taking actions that affect them.

- References to the federal government's relationship with non-federally recognized Tribes and Native American organizations and communities can be found in a number of statutes. Examples include: 25 U.S.C. 1653, administered by the Indian Health Service (IHS); Sec. 802 [42 U.S.C. 2991b], administered by the Administration for Native Americans (ANA); and 42 U.S.C. 8621 et seq., administered by the ACF's Office of Community Services.

Ethical:

- The ethical foundation for this consultation policy is the government-to-government relationship, based on the Constitution, treaties and the cession of lands by American Indians and Alaska Natives in return for the provision of services by the federal government. The federal government's moral obligation to Indian people is derived from this trust relationship.

IV. Definition

Consultation, as defined in the HHS consultation policy, is "an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process which results in effective collaboration and informed decision making."

V. ACF Policy and Plan

In her August 7, 1997 memorandum, Secretary Shalala accepted the HHS Working Group recommendation that "each OPDIV should prepare a draft policy/plan for a consultation process". This policy/plan is a dynamic document that continues to encourage feedback from Tribes and Native communities to ACF.

ACF's Native American consultation policy is divided into two areas -- those issues which are of broad, ACF-wide concern and will be addressed at the OPDIV level; and others which can be addressed by ACF Program offices. The following is an outline of these policies at both levels:

ACF-WIDE POLICY

Form an ACF Working Group on Native American Consultation. Although there are a number of ACF tribal working groups that convene for specific purposes, this would be a formal, ACF-wide workgroup consisting of representation from all ACF Central and Regional offices, including OLAB, OPRE, ORO and OGC. This Working Group on Native American Consultation meets on a regular basis to:

1) Facilitate the process of consultation by ACF programs and the reporting of these activities, as the core of ACF consultation policy.

2) Serve as the link between Programs; staff offices, Intra-Departmental Council on Native American Affairs (IDCNAA), Office of the Assistant Secretary, Office of Intergovernmental Affairs (IGA), and the HHS Working Group on Consultation with American Indians and Alaska Natives.

3) Identify issues for consultation through the establishment of a Native American Focus Group. Representatives would include individuals from those Tribes and organizations listed under Section I, "Purpose", of this document. The ACF Working Group will coordinate with the Focus Group to ensure early inclusion of our partners in this process.

4) Prepare an annual report for submission to IGA by December 31 of each year.

Designate Single Point of Contact (SPOC) Office. The IDCNAA will serve as the SPOC and will coordinate directly with the senior Native American Advisor in IGA and the ACF Executive Secretariat to properly route and disseminate information, memoranda, control correspondence and other materials to ACF Program offices. This SPOC will also have the responsibility of being the point from which Tribes and organizations are referred to the appropriate ACF program staff contact responsible for tribal issues.

The IDCNAA will also ensure that ACF-wide information is on the **ACF/ANA Tribal Resource Web Site** - www.acf.dhhs.gov/programs/ana/council.htm - and on other net sources and sites, as well as those created by individual Program offices. Agency-wide information dissemination, closely coordinated with OPA where appropriate, is also accomplished through other media mechanisms such as telephones, newspapers, magazines, and newsletters to reach those who are not connected through the Internet.

Conferences and meetings. ACF-OAS will coordinate with ACF Tribal Workgroup, the IDCNAA to ensure Native American participation in ACF-wide meetings, conferences, forums, and workshops. When possible, the Assistant Secretary or Principal Deputy Assistant Secretary will meet with Native American leaders at selected conferences/meetings to discuss cross-cutting issues of importance to AI/AN, and Native American communities. This does not replace the ongoing consultation conducted by individual ACF Program offices, but is intended to occur at meetings of national significance and high attendance of tribal leaders, e.g. National Congress of American Indians (NCAI). Conference reports outlining discussion and consultation will be provided to ACF offices and partners for follow-up and feedback.

Written policy-making. When issuing policies that either directly impact AI/ANs or have the potential to affect them, ACF program and staff offices must ensure adequate circulation of these policies to all interested parties.

Performance Standards and Measurement. A critical performance element requiring implementation of this policy shall be made part of the Annual Performance Plan of ACF Senior Management, in those offices where there are specific tribal activities.

PROGRAM OFFICE POLICY

Consultation Policy and Plan Development. Each individual Program is empowered to develop tribal consultation plans that are specifically tailored to their legislative authorities and programmatic concerns. While all ACF components have great latitude in the development of these policies and plans, the implementation of such policies and plans for each Program office should include accomplishing the following:

1) Involvement of partners in the decision-making process; share proposed written policies with Tribes and Native American organizations.

2) Designation of an official staff contact as responsible for the initial coordination and facilitation of the Program office interaction with Tribes and Native American organizations; also serves as the Program SPOC for interaction with offices and workgroups within HHS on AI/AN issues.

3) Assistance to states in their efforts to develop policies and plans to ensure full consultation with all Tribes and Native American organizations.

4) Designing mechanisms to ensure accountability among Program managers, CO and RO staff, and our various partners in carrying out the HHS and ACF Native American consultation

   policies. Incorporate these responsibilities into performance plans for Program management and staff.

5) Ensuring timely feedback to Tribes and Native American organizations on resolution of issues for which consultation has been requested.

6) Ensuring agency-wide information dissemination of the consultation policy and plan on the ACF/ANA Tribal Resource Web Site, as well as all other net sources and sites. Policy and plan information will also be available through a link from the ACF/ANA Tribal Resource Web Site to other net sources and sites. Also included will be other media mechanisms such as telephones, newspapers, magazines, and newsletters to reach those who are not connected with the Internet.

7) Preparation of an annual report by each Program Office on previous fiscal year consultation activities, to be submitted to IDCNAA by November 15 each year. IDCNAA will then compile the Program reports into a single ACF report to be submitted to IGA by December 31 of each year.

VI. Summary

ACF continues to move forward with Department-wide policy recommendations. Initially an ACF Working Group on Native American Consultation was formed with representation from each program office, as well as OLAB, OPRE and OPA. Specific ACF programs have already institutionalized their individual consultation sessions. These programs include the Temporary Assistance for Needy Families (TANF), Office of Child Support Enforcement, Child Care, Head Start and the Children's Bureaus and the Administration for Native Americans.

VII. Contact

Sharon McCully in the Administration for Native Americans' IDCNAA is the point of contact for the ACF Policy and Plan for Native American Consultation. She may be reached by telephone @ (202) 690-5780 telephone, by fax @ (202) 690-7441 or by E-mail smccully@acf.dhhs.gov.

Revised 12/00

Administration on Aging

Plan on Consultation with American

Indian/Alaska Native Tribes and Indian Organizations

1. BACKGROUND

The United States (U.S.) government and the governments of American Indians and Alaska Natives (AI/AN or Indian people) have a unique government-to-government relationship based on the U.S. Constitution, treaties, Federal statutes, court decisions, and Executive Branch policies, as well as moral and ethical considerations. Increasingly this special relationship has emphasized self-determination for Indian people and meaningful involvement by Indian people in federal decision making (consultation) where such decisions affect Indian people, either because of their status as Indian people or otherwise.

Consistent with these principals, the President issued an Executive Memorandum on April 29, 1994, titled, "Government-to-Government Relationship with Native American Tribal Governments." This Memorandum states that in all activities relating to or affecting the government or treaty rights of Indian tribes, the executive branch shall:

a. operate within a government-to-government relationship with federally recognized Indian tribes;

b. consult, to the greatest extent practicable and permitted by law, with Indian tribal governments before taking actions that affect federally recognized Indian tribes;

c. assess the impact of agency activities on tribal trust resources and assure that tribal interests are considered before the activities are undertaken;

d. remove procedural impediments to working directly with tribal governments on activities that affect trust property or governmental rights of the tribes; and

e. work cooperatively with other agencies to accomplish these goals established by the President.

The President issued Executive Order 13084, dated May 14, 1998 and titled "Consultation and Coordination with Indian Tribal Governments", to establish regular and meaningful consultation and collaboration with Indian tribal governments:

a. in the development of regulatory practices on Federal matters that significantly or uniquely affect their communities;

b. to reduce the imposition of unfunded mandates upon Indian tribal governments; and

c. to streamline the application process for and increase the availability of waivers to Indian tribal governments.

On August 7, 1997, the Secretary, Department of Health and Human Services (DHHS) issued a memorandum establishing the DHHS policy on consultation with American Indian/Alaska Native Tribes and Indian organizations. In addition to establishing DHHS wide policy, this memorandum directed each agency to develop their own individualized consultation plan consistent with DHHS policy.

Consultation examples include:

a. Provisions in the Older Americans Act (42 U.S. C. 3001) (OAA) that state:

"The Assistant Secretary shall consult and coordinate with State agencies, area agencies on aging, and recipients of grants under title VI in the development of federal goals, regulations, program instructions, and policies under this Act (Sec. 203A); and "the Assistant Secretary shall, in developing priorities, consistent with the requirements of this title, for awarding grants and entering into contracts under this title, consult annually with State agencies, area agencies on aging, recipients of grants under title VI, institutions of higher education, organizations representing beneficiaries of services under this Act, and other organizations, and individuals, with expertise in aging issues (Sec 402 d)."

b. Departmental regulations implementing the Indian Self-Determination Act, as amended, such as:

"It is the policy of the Secretary to facilitate the effort of Indian tribes and tribal organizations to plan, conduct, and administer programs, functions, services and activities, or portions therof, which the departments are authorized to administer for the benefit of Indians because of their status as Indians..."

c. Federal laws such as the Unfunded Mandates Reform Act of 1995, P.L. 104-4, which states:

"The purposes of this Act are.., to assist Federal agencies in their consideration of proposed regulations affecting. . . Tribal governments by. .. requiring that Federal agencies develop a process to enable.. .Tribal governments to provide input when Federal agencies are developing regulations, and requiring that Federal agencies prepare and consider the budgetary impact of Federal regulations containing Federal mandates upon. . . Tribal governments before adopting such regulations (Sec.2)."

2. PURPOSE

To establish an Administration on Aging (AoA) policy on consultation with AI/AN tribal governments; reaffirm the AoA's recognition of the sovereign status of federally recognized Indian tribes; to reaffirm adherence to the principles of government-to-government relations; to inform AoA personnel, other federal agencies, federally recognized Indian tribes, the aging network, and the public of AoA's working relationships with federally recognized Indian tribes.

3. DEFINITION

Consultation: Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which lead to mutual understanding and comprehension. Consultation is integral to a deliberative process which results in effective collaboration and informed decision making.

4. AOA PARTICIPATION IN DEPARTMENT LEVEL ACTIONS

Consistent with the DHHS policy, AoA will provide a list of suggested participants to attend the annual meeting convened for the department. The purpose of this annual meeting is to provide and opportunity for Indian people to present their appropriation needs and priorities. This meeting will take place before AoA submits its budget requests to the department (probably in May of each year). Before each meeting, a

summary of the previous year's departmental budget will be made available as a basis for discussion to all consultation participants.

The AoA will coordinate with other agencies in determining other issues or priorities for legislation or cross cutting initiatives require department level consultation.

The AoA designated single point of contact for program information and assistance will be the Director of American Indian, Alaskan Native, and Native Hawaiian Programs.

5. AOA LEVEL ACTIONS

a. With advice and consultation from tribal governments, AoA will identify critical events at which tribal consultation and participation will be required. This will be accomplished within 120 days of approval of this plan.

Although the principal focus for consultation and participation activities of AoA is with individual tribal governments, it is important that AoA solicit advise and involvement from title VI directors, national Indian aging organizations, and other AI/AN organizations interested in issues affecting AI/AN elders.

Focus group sessions will be held to solicit tribal comments and recommendations on legislation and budget matters affecting AI/AN elders. Issue sessions at roundtables, forums, and meetings will provide the opportunity for meaningful and effective participation by AI/AN elders and organizations in the planning of the AoA programs and services.

The Government Performance and Results Act (GPRA) is intended to help Federal programs succeed by identifying what constitutes successful program performance, what resources are needed and what challenges exist which affect achieving success. GPRA also requires accountability. Consultation with AI/AN will assures that the AoA programs achieve success.

b. The AoA will assist states in developing mechanisms for consultation with their AI/AN governments and Indian organizations before taking any actions that affect these governments and/or Indian people. States will receive assistance in developing state plan assurances for the delivery of services to older Indians.

State consultation with AI/AN should be done in a meaningful manner that is consistent with the definition of "consultation" as defined in this policy plan.

AoA will assure that State plans on consultation with AI/AN are successful by convening conferences with States, AI/AN tribes and organizations, and Area Agencies on Aging to develop a set of consultation protocols. The developed protocols will be used in the evaluation of States efforts to consult with AI/AN governments and organizations. Technical assistance and monitoring will be provided by AoA Regional Office staff.

Specific mechanisms that will be used to consult with tribal governments are: mailings, meetings, teleconferences, and roundtables.

c. The OAA authorizes three programs which are especially relevant to AI/AN elders:

1) Title VI promotes the delivery of supportive services, including nutrition services to American Indian, Alaskan Native, and Native Hawaiians;

2) Title Ill encourages and assist State and Area Agencies on Aging to concentrate resources in order to develop a greater capacity and foster the development and implementation of comprehensive and coordinated systems to serve older individuals; and

3) Title IV provides grant support to expand the nation's knowledge and understanding of aging and the aging process and design and test innovative ideas in programs and services for older individuals.

With respect to these programs, the AoA will make available sufficient background information to AI/AN tribes on which consultation is requested. There will be a clear statement of the advice requested, and a specific time frame for response from consulted entities, a clear indication of who should receive the reply, and a clear statement of potential impact on Indian people.

d. The AoA upon completion of consultation will determine if there are any unresolved issues that would benefit from ongoing involvement of AI/AN elders in implementation and evaluation. The AoA will include a mechanism to address this need.

e. The AoA will consult with AI/AN leaders on the "reviewed" policy/plan to provide for effective and meaningful participation by AI/AN.

f. The single point of contact within AoA for tribal governments and other Indian people, at a level with access to all OPDIV/STAFFD IV, is the Director, Office for American Indian, Alaskan Native, and Native Hawaiian Programs. This office will assist the department's point of contact in the IGA in accessing department-wide information and will provide a single entry point to HHS-wide information.

g. The AoA's consultation plan will be posted on the AoA website homepage, appropriate American Indian websites, and published in the Federal Register soliciting comments. Tribes will be given access to AoA's consultation with sufficient time to respond before any final decisions are made.

h. The AoA will continue to inform tribal leaders on consultation policy by holding meetings, roundtables, teleconferences, forums, and placing information on the AoA website homepage and other appropriate websites. AoA will also do mass mailings on specific consultation issues.

SUMMARY:

The AoA considers consultation an evolving process. The AoA's central and regional offices have established relationships with Tribal governments and organizations with whom they communicate about the AoA programs. This joint partnership will ensure implementation of the consultation plan, make recommendations for revisions based upon periodic assessments and assure that Tribal issues are promptly addressed.

American Indian/Alaska Native Consultation Plan

Agency for Healthcare Research and Quality

I. BACKGROUND

On April 29, 1994 President Clinton issued an Executive Memorandum addressing government-to-government relations with American Indian and Alaska Native (AI/AN) tribal governments (see Tab A). As part of that Executive Memorandum, the President directed that each Department "consult, to the greatest extent practicable and to the extent permitted by law, with tribal governments prior to taking actions that affect federally recognized tribal governments."

In response to this directive, the Domestic Policy Council's (DPC's) Working Group on Indian Affairs spent over a year attempting to develop a government-wide tribal consultation policy. The DPC decided that such a uniform policy by all federal agencies was not feasible or desirable and recommended that each Department develop its own individualized consultation policy. The DPC identified six points that should be addressed by each Department's consultation policy (see Tab B).

In response to these actions, the Department of Health and Human Services (DHHS) formed a Working Group on Tribal Consultation, co-chaired by Dr. Jo Ivey Boufford, Office of Public Health Science (OPHS), and Dr. Michael Trujillo, Director, Indian Health Service (IHS). The group developed a departmental consultation plan which calls for Agency-specific plans to be developed and joined together along with any other Department-wide consultation processes deemed necessary (see Tab C).

Recently, on November 6, 2000, the President issued a new Executive Order on "Consultation and Coordination with Indian Tribal Governments." This Executive Order, which revoked a previous Executive Order issued on the same subject of May 14, 1998 (E.O. # 13084), emphasizes the unique government-to-government relationship between the federal government and tribal governments and the right of tribes to self-government. Among other things, the Executive Order requires that each federal department have a process in place to ensure "meaningful and timely" input by tribal officials in the development of regulatory and other policies that have "substantial direct effects" on one or more tribes, the relationship between the Federal Government and tribes, or the distribution of power between the Federal Government and tribes.

II. DEPARTMENTAL CONSULTATION PLAN

The departmental plan lays out the legal foundations and overall policy decisions which are to guide Agencies (see Tab C). It also lays out the following definition of "consultation."

> "Consultation is an enhanced form of communication which emphasizes trust and respect. It is a shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension.
> Consultation is integral to a deliberative process which results in mutually satisfying collaboration and decision making."

The departmental plan also lays out the foundations for conducting consultation with both federally-recognized tribes and other, non-federally recognized AI/AN organizations (see pages 1-5, Tab C).

Among other key points, the departmental plan:

- recommends that the IHS, the Administration for Native Americans (ANA), and the Office of Minority Health (OMH) convene an annual consultation meeting of representatives from AI/AN organizations on behalf of the Department;
- establishes a single point-of-contact that can provide AI/AN leaders with easy access to Departmental program information and assistance;
- requires that each Agency develop an explicit proposal for a consultation process; and
- directs that Agencies use the Internet in communicating with AIs/ANs.

III. AHRQ CONSULTATION PLAN

Consistent with Departmental policy, it will be the policy of the Agency for Healthcare Research and Quality (AHRQ) to consult with AI/AN tribal governments and other AI/AN organizations, as appropriate, to the greatest practicable extent before taking actions that significantly and/or uniquely affect them and/or their communities. This consultation plan will be updated as tribal consultation needs become more clear or change.

In line with departmental guidance found in Tab C, AHRQ proposes to do the following.

- Information--AHRQ will send a package of information on the Agency, its mission, the type of work it undertakes, accomplishments, etc. to all AI/AN tribal governments and other organizations included in the universe of groups from which the departmental consultation group is drawn. AHRQ will request input from the tribes and other AI/AN organizations contacted on their consultation needs, desires, and expectations. More specifically, the Agency will seek input on what subjects or issues the Agency should seek consultation, how often, and with whom the Agency should work.

- Consultation--Pending input from tribal governments and other AI/AN organizations (see above), AHRQ will piggy-back on the annual departmental AI/AN consultation meeting to discuss pending proposals, programmatic activities, and/or budgetary changes significantly affecting AI/AN tribal governments, other AI/AN organizations, and their communities.

  If there is a need for consultation between annual meetings in order to gain input from tribal governments and other appropriate AI/AN organizations early in a decision making process, AHRQ will either: 1) pull together a meeting of the departmental advisory group of tribal leaders and leaders of other appropriate AI/AN organizations used during annual budget consultations; 2) consult with the members of that group through conference calls, mail, etc.; or 3) send out a mailing to all tribal governments and other appropriate AI/AN organizations from which AHRQ is seeking input.

- Feedback--On any matters for which AHRQ seeks consultation, it will provide feedback to, at minimum, those from whom the Agency sought input, if not all tribal governments and leaders of all other affected AI/AN organizations.

- Communication on the Internet–Consistent with departmental policy, AHRQ will post its consultation plan on its Home Page on the Internet--www.ahrq.gov–and seek to link it to other webpages frequented by AI/AN leaders, including those of the IHS, Association of American Indian Physicians, and Codetalk . The AHRQ website includes a large amount of information about the Agency and its work.

  Communication will not be limited to the Internet. A copy of the consultation plan and subsequent requests for consultation will also be sent to all tribal governments and other appropriate AI/AN organizations by regular mail.

Agency for Toxic Substances and Disease Registry

Consultation and Coordination Policy with Indian Tribal Governments

ATSDR's mission is to prevent exposure and adverse human health effects and diminished quality of life associated with exposure to hazardous substances from waste sites, unplanned releases, and other sources of pollution present in the environment.

ATSDR is committed to assisting tribal governments meet the environmental health needs of their people. ATSDR continues to work to improve its communication and cooperation with tribes. This new policy is in response to the Presidential Executive Order 13084, Consultation and Coordination With Indian Tribal Governments, May 14, 1998, and affirms the current ATSDR Policy on Government-to-Government Relations with Native American Tribal Governments (61 FR 42255). The policy focuses on environmental health issues related to the release of hazardous substances into the environment.

Consultations between ATSDR and tribal governments will continue to ensure effective collaboration in identifying, addressing, and satisfying the needs of tribal communities affected by hazardous substances. Consultation enables ATSDR staff and tribal members to interactively participate, exchange recommendations, and provide input on environmental health activities.

As defined by ATSDR, the new policy supports

(1) a consultative process with tribal nations and their members to work together to address tribal environmental public health needs

(2) mutual trust, respect, and shared responsibilities between all participating parties

(3) open communication of information and opinions leading to mutual interaction and understanding.

ATSDR

- Respects and honors the sovereignty of the tribes, the responsibilities and rights to self-governance, and the differences between tribal nations and individuals.
- Consults with tribal governments to ensure community concerns and impacts are carefully considered before the Agency takes action or makes decisions affecting tribal communities.
- Maintains government-to-government relationships with tribal governments.
- Ensures ongoing communication with tribal governments, communities, and individual tribal members to define concerns about possible health impacts from exposure to hazardous substances.

TRIBAL CONSULTATION PLAN
Centers for Disease Control and Prevention

Introduction/Background

The Centers for Disease Control and Prevention (CDC) is committed to improving the public health of American Indian/Alaska Native (AI/AN) communities, and recognizes both the unique relationship it has with its AI/AN constituents and the cultural diversity of that constituency. To formally guide its efforts to develop and implement a tribal consultation policy, CDC has established an agency-wide Tribal Consultation Working Group (TCWG), four members of which are American Indians. In addition to the TCWG, CDC has established two full-time professional staff positions within the Office of the Director to help plan and coordinate CDC programs for AI/AN communities: 1) the American Indian/Alaska Native Health Program Specialist and 2) the Senior CDC/ATSDR Tribal Liaison. Located in Atlanta, GA and Albuquerque, NM, respectively, these CDC staff members report directly to the Associate Director for Minority Health and serve as CDC points-of-contact for programs/issues relevant to issues of AI/AN public health (Appendix 1).

CDC's commitment to AI/AN public health is further demonstrated by the active engagement of more of its professional staff in broader, more systematic efforts to partner with AI/AN communities across the United States. Prominent among these efforts is the placement of CDC staff in situations that enhance tribal access to CDC personnel and resources (e.g., at least 12 CDC professionals field-assigned to work exclusively on AI/AN issues in Indian Country). CDC is also expanding its partnerships with the Indian Health Service (IHS) through multiple intra-agency agreements, collaborative projects, and the establishment of a Senior IHS-CDC Policy Group. A priority for IHS-CDC partnerships is the expansion of the Tribal Epidemiology Centers Program. Overall, CDC and its partners (tribal governments/communities, state health departments, academic institutions, and other federal organizations) are addressing multiple health issues that affect AI/AN communities including, but not limited to, diabetes, injuries, tobacco use, cardiovascular health, cancer, maternal-child health, and infectious diseases such as HIV/AIDS, other sexually transmitted diseases, hepatitis, antibiotic-resistant bacterial infections, and hantavirus.

The CDC Mission

The mission of the Centers for Disease Control and Prevention is to promote health and quality of life by preventing and controlling disease, injury and disability. CDC accomplishes its mission by working with partners throughout the United States and the world to monitor health, detect and investigate health problems, conduct applied research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training. CDC's priorities are:

< Strengthen science for public health action

< Collaborate with health care partners for prevention

< Promote healthy living at all stages of life

< Work with partners to improve global health

CDC Policy on Tribal Consultation

The Centers for Disease Control and Prevention will honor the sovereignty of American Indian/Alaska Native Governments, respect the inherent rights of self governance and commit to work on a government-to-government basis. The CDC will confer with Tribal Governments, Alaska Native Organizations and AI/AN communities, before taking actions and/or making decisions that affect them. Consultation will include all AI/AN governments and organizations.

As does the Department of Health and Human Services, CDC considers consultation to be "an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process which results in effective collaboration and informed decision-making."

Development and Implementation of the CDC Tribal Consultation Policy

In addition to the establishment of the CDC TCWG and primary points-of-contact within the Office of the Director, CDC has implemented an annual budget planning and priorities meeting wherein tribal leaders and other representatives can consult with CDC leadership early in the FY budget development process. This yearly process will serve to facilitate the development of new budget initiatives and increase the consideration of AI/AN public health issues by CDC's various centers, institutes, and offices.

The next steps in CDC's tribal consultation development process will be to systematically solicit tribal input. This process will begin with broad-based notification of tribal leaders, AI/AN organizations, community members, and others that CDC is developing it's formal tribal consultation policy and is seeking AI/AN input regarding the implementation of that policy. Publications and organizations to target for notification include, but are not limited to, *Indian Country Today*; *Indian News*; the National Congress of American Indians; the National Indian Health Board; the newsletters of the American Indian Science and Engineering Society and American Indian Higher Education Consortium; *Tribal College Journal*; tribal health department newsletters; and AI/AN-focused websites. Thereafter, presentations/workshops will be developed wherein CDC senior staff have the opportunity to present Agency intentions and solicit input from elected tribal leaders regarding the content, steps, and program needs for CDC's Tribal Consultation Policy. These presentations/workshops would be held in conjunction with established national and regional AI/AN meetings as outlined below:

National Meetings:
National Congress of American Indians
National Indian Health Board
Association of American Indian Physicians
Indian Health Service Annual Research Conference
Indian Health Leadership Council of the IHS

*Regional Health Board Meetings**
Aberdeen Area
Alaska Area
Albuquerque Area
Billings Area

Bemidji Area
California Area
Nashville Area
Navajo Area
Oklahoma Area
Phoenix Area
Portland Area
Tucson Area

*(*NOTE:* The CDC will invite **all Tribal leaders and representatives** within the each respective region regardless of whether or not they are affiliated with the Area Health Board or National Organization.)

The document attached as Appendix 2 (Request for Comments Worksheet) has been used to solicit tribal input about this development process. It was distributed at the DHHS National Tribal Consultation Forum in Washington, D.C. in July, 2000 and again at the National Indian Health Board conference in Billings, MT in August, 2000.

Upon completion of the national/regional meetings, a draft tribal consultation implementation document will be prepared and submitted to NIHB, NCAI, and tribal governments for review and final comment. Thereafter, the finalized document will be presented to NCAI for final approval by resolution. Once this resolution is enacted, the final document will be published in the Federal Register, posted on appropriate federal and AI/AN websites, and made widely available to AI/AN governments and organizations.

Framework for Tribal Consultation

In order to facilitate discussion and identify key areas of focus for the consultation process, the CDC TCWG has proposed a framework for tribal consultation. The intent of this framework is to establish a mutually acceptable process of communication between AI/AN people and CDC. The task is to establish protocol and to identify health problems and priorities for both entities so that the needs of AI/AN populations are incorporated into CDC plans and programs.

The following areas are not mutually exclusive or all inclusive with respect to consultation; they represent some of the issues that can assist us in guiding the process of implementing the CDC tribal consultation policy. Potential topical areas for tribal consultation include:

- **Infrastructure and Support**
- **Budget, Policy Initiatives and Resource Allocation**
- **Program Development and Implementation**
- **Research**
- **Surveillance**
- **Technical Assistance, Capacity Building and Training**
- **Communication**
- **Building Stronger Linkages**
- **Monitoring, Evaluation and Quality Assurance**

Conclusion

As recently reaffirmed by Executive Order No. 13175 (November 6, 2000), the United States government maintains a unique relationship with American Indians and Alaska Natives (AIs/ANs). Based upon Article I, Section 8 of the United States Constitution, in addition to numerous treaties, legislation, Supreme Court decisions, and Executive Orders, the U.S. government must relate to federally recognized tribes on a government-to-government basis. Inherent to this relationship is the federal trust responsibility, which, in part, includes an obligation to ensure that tribal members attain the highest health status possible. As a federal agency, CDC recognizes its special obligations to, and unique relationship with, the AI/AN segment of the U.S. population, and is committed to fulfilling its critical role in assuring that AI/AN communities are safer and healthier.

Appendix

1. Points of contact for AI/AN health within CDC

2. Request for Comments Worksheet

Appendix 1.

CDC Contacts for American Indian/Alaska Native Activities:

In Atlanta:

Position: American Indian/Alaska Native Health Program Specialist, Office of the Director, CDC, Atlanta, GA.

Purpose: To serve as an advisor to the Associate Director and be responsible for the planning, coordination, and evaluation of health prevention, educational programs, and research specifically for American Indian/Alaska Native (AI/AN) governments and organizations.

Contact: Dean Seneca, MPH*
Office of the Associate Director for Minority Health,
Office of the Director,
Centers for Disease Control and Prevention, MS-D39
1600 Clifton Rd., NE
Atlanta, GA 30333
(404) 639-7220 - TEL; (404) 639-7039 - FAX
E-Mail: zkg8@cdc.gov

**Note:* Mr. Seneca is in transition to the Agency for Toxic Substances and Disease Registry; we will announce the name of his replacement as soon as this information is available.

In Albuquerque:

Position: Senior CDC/ATSDR Tribal Liaison; Office of the Director, CDC; c/o IHS Epidemiology Program, Albuquerque, NM

Purpose: Strengthen inter-governmental response to tribal public health needs through consultation, networking, strategic planning, and improved coordination among federal and state governments, tribal communities, urban Indian health programs, and academic institutions.

Contact: Ralph T. Bryan, MD
Senior CDC/ATSDR Tribal Liaison
Office of the Associate Director for Minority Health,
Office of the Director,
Centers for Disease Control and Prevention
c/o IHS Epi Program
5300 Homestead Rd. NE
Albuquerque, NM 87110
(505) 248-4226 - TEL; (505) 248-4393 - FAX
E-Mail: rrb2@cdc.gov

Appendix 2. Request for Comments Worksheet

Please complete the following questions regarding the Centers for Disease Control and Prevention (CDC) Tribal Consultation Policy. Please PRINT. Thank you.

1. What do you consider most important regarding Tribal Consultation?

2. At this stage of development, does the consultation policy/approach clearly state the intent of the CDC in assisting American Indian/Alaska Native (AI/AN) governments and organizations in providing health promotion and disease prevention services?

3. What services and technical assistance would you like CDC to provide as part of the Consultation Policy?

4. Would you recommend/prefer to have a National or Local AI/AN organization assist CDC in the exchange of dialogue as a method for developing its Tribal Consultation Policy? (If so, please provide us with the name of an organization you would recommend.)

Please tell us who you represent. Check all that apply. Thank you

___ Elected Tribal Official
___ Tribal Member
___ Tribal Representative
___ Tribal Elder
___ Other - please tell us more _____

___ Community-based organization
___ Clinician
___ Professional association
___ Academic institution

Optional: Your Name_____ **Phone:**_____ **Fax:**_____

U.S. FOOD AND DRUG ADMINISTRATION
CONSULTATION POLICY - TRIBAL GOVERNMENTS

I. MISSION

The Food and Drug Administration (FDA) is a science-based regulatory and consumer protection agency. FDA accomplishes its mission by enforcing the Food, Drug and Cosmetic Act (the Act) and subsequent regulations.

FDA is responsible for ensuring that: (1) Foods are safe, wholesome and sanitary; human and veterinary drugs, biological products, and medical devices are safe and effective; cosmetics are safe; and electronic products that emit radiation are safe; (2) regulated products are honestly, accurately and informatively represented and meet the law and FDA regulations; (4) noncompliance is identified and corrected; and that (5) any unsafe or unlawful products are removed from the marketplace.

II. TRUST RESPONSIBILITIES

The special relationship between the Federal government and the tribes is grounded in many historical, political, legal, moral, and ethical considerations. Involvement by Indian people in Federal decision-making has increased where such decisions affect Indian people, either because of their status as Indian people or otherwise.

FDA will work to meet its responsibilities to tribes. These responsibilities are derived from the Federal trust doctrine (i.e., the trust obligation of the United States Government to the tribes, and Treaties, Executive Orders, Agreements, Statutes, and other legal obligations between the Federal government and the tribes.

III. GOVERNMENT TO GOVERNMENT RELATIONS

This policy[1] covers FDA's intent, to the extent permitted by law, to interact and work with federally recognized American Indian and Alaska Native governments (hereinafter referred to as "tribes[2]".) This policy outlines FDA's intent to:

- support tribal self-governance and government-to-government relations between the United States and the tribes;
- recognize the importance of increasing understanding and addressing tribal concerns, past, present, and future; and
- recognize the importance of addressing tribal concerns before reaching decisions on matters that may significantly impact on protected tribal resources[3], tribal rights, and Indian lands[4].

FDA will work to build stable and enduring relationships with tribes by:

- communicating with tribes on government-to-government basis in recognition of their sovereignty,

- requiring meaningful communication with the tribes to address concerns between the tribes and the Agency at both the tribal leadership-to-Agency level and the tribal staff-to-regional and district staff levels, and

- designating appropriate senior points of contact within FDA to ensure that tribal inquiries are channeled to appropriate officials within FDA and receive timely responses.

V. CONSULTATION

Through this policy, consultation means, an enhanced form of communication that emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is important to a deliberative process that results in mutually satisfying collaboration and decision making. Examples of consultation may include:

- assessing the effect of proposed FDA actions that may have the potential to significantly affect protected tribal resources[3], tribal rights, and Indian lands before decisions are made;

- providing affected tribes an opportunity to participate in the decision-making process that will ensure these tribal interests are given due consideration in a manner consistent with tribal sovereign authority;

- taking appropriate steps to remove any procedural or regulatory impediments to FDA working directly and effectively with tribes on activities that may have the potential to significantly affect protected tribal resources, tribal rights, and Indian lands;

- working with other federal and state agencies and tribally recognized entities, in consultation with tribes, to minimize duplicative requests for information from tribes.

- consulting consistent with government-to-government relations and in accordance with protocols mutually agreed to by a particular tribe and FDA, including necessary dispute resolution processes;

- providing timely notice to, and consulting with, tribal governments prior to taking any actions that may have the potential to significantly affect protected tribal resources, tribal rights, or Indian lands; and

- consulting and negotiating in good faith throughout the decision-making process.

Through this consultation process FDA, tribes, and tribally recognized entities, may work to accomplish goals such as:

- to express of views on a particular policy, proposed action or activity, and elicit tribal reactions.

- to bring a tribal initiated health issues to the FDA's attention to obtain the Agency's perspective on the issue.

- to educate tribes about issues, activities, or programs resulting in a greater understanding of the FDA.

- to enhance local consultations and collaborations between the FDA field offices closest to tribal governments, when appropriate,

- to improve access of American Indians and Alaska Natives to FDA generated information on health risks and policy issues,

VI. NATURAL AND CULTURAL RESOURCES PROTECTION

FDA recognizes and respects the significance tribes ascribe to certain natural resources and properties of traditional or customary religious or cultural importance by:

- Taking actions consistent with the conservation of protected tribal resources and in recognition of Indian treaty rights to fish, hunt, and gather resources at both on-and off-reservation locations;

- enhancing, to the extent permitted by law, tribal capabilities to effectively protect and manage natural and cultural tribal trust resources whenever FDA acts to carry out a program that may have the potential to significantly affect those tribal trust resources;

- developing tribal specific protocols to protect, to the maximum extent practicable and consistent with the Freedom of information Act, Privacy Act, National Historic Preservation Act, and Archeological Resources Protection Act, tribal information regarding protected tribal resources that has been disclosed to, or collected by the FDA.

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1. This policy is not intended to, and does not, grant, expand, create, or diminish any legally enforceable rights, benefits, or trust responsibilities, substantive or procedural, not otherwise granted or created or created under existing law. Nor shall this policy be construed to alter, amend, repeal, interpret, or modify tribal sovereignty, or treaty rights, or other rights or any Indian tribes, or to preempt, modify, or limit the exercise of any such rights.
2. As defined by most Department of Interior/Bureau of Indian Affairs lists of tribal entitles published in Federal Register pursuant to Section 104 of the Federally Recognized Indian Tribe List Act.
3. Protected Tribal Resources: Those natural resources and properties of traditional or customary religious or cultural importance, either on or off Indian lands, retained by, or reserved by or for, Indian tribes through treaties, statutes, judicial decisions, or executive orders or agreement, and that give rise to legally enforceable remedies.
4. Indian Lands: Any lands title to which is either: 1) held in trust by the United States for the benefit of any Indian tribe or individual; or 2) held by any Indian tribe or individual subject to restrictions by the United States against alienation.

HEALTH CARE FINANCING ADMINISTRATION
POLICY STATEMENT FOR CONSULTATION WITH
AMERICAN INDIAN/ALASKA NATIVE (AI/AN) GOVERNMENTS

This Health Care Financing Administration (HCFA) policy on consultation with AI/AN Governments responds to the 1998 Executive Order on Government-to-Government Relations with Native American Tribal Governments, directives from the White House Domestic Policy Council Working Group on Indian Affairs, and recommendations from the Departmental Working Group on Consultations with American Indians and Alaska Natives. The **guiding principle** of the policy is to ensure that, pursuant to the special relationship between the United States Government and the Tribal Governments and to the greatest extent practicable and permitted by law, broad based input is sought by HCFA prior to taking actions that have the potential to affect Federally recognized tribes.

HCFA acknowledges and accepts the following definition of consultation as developed by the HHS Working Group.

> "Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process which results in an effective collaboration and informed decision making."

HCFA' s consultation process will address all policies, regulations, and statutes applicable to the Medicare, Medicaid, and State Children's Health Insurance programs, including but not limited to eligibility, coverage, reimbursement, certification, and quality standards issues. With respect to the Medicaid program, HCFA will require State participation in certain critical program change situations; such as, implementation of State-wide health care reform waivers and other waiver programs which clearly affect Indian people. HCFA will strongly encourage the inclusion of Tribal groups in the development of other State health program proposals. All consultation processes will be mindful of the Government-to-Government relationship which exists between the Tribes and HCFA.

A. Goals of the Consultation Strategy

HCFA has two primary goals for its consultation process:

1. Establishing and Maintaining Communications

   HCFA shall establish improved communication channels with Tribal officials and other AI/AN organizations as appropriate to increase knowledge and understanding of the Medicare, Medicaid, and State Children's Health Insurance programs. HCFA will, in turn, learn from Tribal governments and organizations of the needs and concerns of their members, providers and health care partners serving the AI/AN population. HCFA shall consult with Tribes about communication methods.

   A variety of methods and mechanisms will be necessary to effect communication with the *558* Federally recognized tribes; for example, use of the Internet and other information technology may be necessary and appropriate in many situations. In some cases, face-to-face or other two-way communication will be needed, for example, the introduction of major legislative change in our programs.

2. Establishing and Maintaining Ongoing Consultation Mechanisms

As HCFA enhances its communication channels with the Tribes, consultation will occur promptly and effectively and as an acknowledged part of daily business. HCFA will share information with the Tribes and seek their input into proposed changes in the operation of the Medicare and Medicaid programs that have the potential to impact the lives of AI/AN individuals. Any proposed program changes will be communicated to the Tribes as early in the process as is practicable and appropriate.

Inherent in the ongoing consultation processes within HCFA is the need for technical assistance to Tribes in realizing the full potential of the Medicare, Medicaid, and State Children's Health Insurance program benefits for AI/AN beneficiaries and for providers of health services. In addition, HCFA will strive to resolve problems and issues in a focused manner which is, as always, mindful of the Government-to-Government relationship as well as legal, fiscal and political constraints.

B. Responsibility for Consultation

Responsibility for ensuring the consultation strategy is implemented, maintained, and continually improved and adapted to change, is vested in a joint partnership between HCFA's headquarters and its regional offices. The Intergovernmental and Tribal Affairs Group (IGTAG), the Director of the Center for Medicaid and State Operations (CMSO), and the Regional Administrator in Seattle as the lead for all field activities, share joint responsibility for establishing effective communication mechanisms with Tribes and for ensuring effective ongoing consultation with Tribes.

C. Implementation Steps

1. Definition of Core Consultation Issues

The Regional Office and CMSO, including IGTAG, with consultation from Tribes will develop a core group of issues and activities on which consultation will be sought or the criteria that will be used to identify such issues. Waivers and legislation affecting Tribes are considered critical for consultation.

2. Training of Staff

HCFA staff will participate in a training session on the Consultation Policy Statement and Agency expectations on a regular basis. The sessions may be by meeting, conference call, other broadcast or video format.

3. Ongoing Consultation with Tribes

Where feasible, it is assumed that there is great value to both the Tribes and federal staff to conduct regular face-to-face meetings with the Tribes and/or to seek opportunities to participate in meetings conducted for the Tribes by others. These face-to-face meetings will provide additional and more issue-specific opportunities for HCFA staff to seek and receive feedback from the Tribes on the consultation process, to provide technical assistance, and to assist in resolving problems and issues. Identification and resolution of issues will take place largely at the Regional level. Central Office personnel will be included in the consultation process and/or the

Regional Office will provide information based on consultation in order to inform the policy making process.

D. Additional Policies and Guidance in Consulting with Tribes

1. A variety of mechanisms (e.g., Internet Web sites, meetings, telephones, newspapers, magazines and newsletters) will be explored and utilized to ensure timely and consistent exchange of information between the HCFA Offices/Staff and the Tribes.

2. Consultation will occur directly between the HCFA and the Tribes. While other interested organizations may also receive information and be asked for input, the primary mechanism for consultation by the HCFA will be direct communication with the Tribes.

3. When consultation is sought from the Tribes, sufficient explanation of the issue and potential for impact on the Tribes will be provided by the HCFA Office/Staff. All requests for input by the Tribes will state clearly what advice is requested and the time frame for response. As far as practicable, time frames will be of sufficient duration to allow communication by the Tribal Leaders with their constituency.

4. Tribes which provide advice or comments back to the HCFA during a consultation process will be provided with timely feedback on the disposition of the issue for which consultation was requested. Time frames will be of sufficient duration to allow communication by the Tribal Leaders with their constituency.

5. HCFA will ensure that states notify Tribes of proposed changes to state programs impacting Tribal members. HCFA will also strongly encourage the inclusion of Tribal groups in the development of state proposals.

6. Although no government-to-government relationship exists between the HCFA and urban Indian centers, significant numbers of AI/AN beneficiaries receive health services at these locations. Consultation with these centers is also encouraged whenever possible.

Summary: Consultation is viewed by the HCFA as an evolving process. The joint partnership between the Center for Medicaid and State Operations (CMSO), intergovernmental and Tribal Affairs Group (IGTAG), and the lead Regional Office will provide leadership for the implementation of the HCFA Consultation Policy. Together the IGTAG and the lead Regional Office will ensure implementation of the Policy, make recommendations for revisions to the Policy based upon periodic assessments, and assure that issues surfaced by the Tribes are addressed promptly.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)
AMERICAN INDIAN/ALASKA NATIVE POLICY STATEMENT
AND
TRIBAL CONSULTATION PLAN

Policy Statement

The mission of the Health Resources and Services Administration (HRSA) is to improve the health of the Nation by assuring quality health care to underserved, vulnerable, and special need populations and by promoting appropriate health professions workforce capacity and practice, particularly in primary care and public health. Within the purview of this mission, it is the policy of HRSA to invite participation by elected Tribal officials and to solicit assistance from Tribal senior staff, tribal organizations, and other Indian people regarding the conceptualization, development, and implementation of culturally appropriate HRSA policies and programs that will directly or indirectly have an impact.

Applicable statutes and policies pertaining to this policy are attached.

For the purposes of this plan, consultation is defined as follows:

Consultation is an enhanced form of communication which emphasizes trust and respect. It is a shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process which results in mutually satisfying collaboration and decisionmaking whenever possible.

HRSA's Action Plan for Tribal Consultation

HRSA recognizes its Federal responsibilities under applicable statutes and policies and will consult and cooperate with American Indian/Alaska Native (AI/AN) tribes and other Indian people. Consultation will occur directly between HRSA and the Tribes. While other interested organizations may also receive information and be asked for input, the primary mechanism for consultation will be direction communication with Tribes. HRSA will fulfill these consultation responsibilties in the following ways:

- take the lead in developing integrated and linguistically and culturally appropriate systems of care and an appropriate health workforce within the U.S. to help assure access to essential health care of high quality, independent of cultural and linguistic factors, geographic location, or economic circumstances through innovative and supportive collaborations with Tribal governments and partnerships with American Indian and Alaska Native organizations and with Indian people.

- ensure that cultural competence is an integral component of HRSA programs targeted to AIs/ANs by developing partnerships with local tribal governments and communities, universities that serve the AI/AN population, spiritual and non-traditional healers and national and community based organizations.

- strengthen and enhance Federal partnerships with States to ensure that the health needs of Indian people within States are being met.

- identify barriers and problems related to access to care for AIs/ANs and develop targeted strategies to eliminate these barriers, with the goal of increasing access to care.

- establish and maintain a more focused and expanded approach to communicating and consulting with AI/AN tribes and other Indian people on an on-going basis.

- develop an overall communication plan for utilizing the many communication pathways available to involve Indian people in HRSA decisionmaking, including developing innovative ways to provide information on programs to tribes and gain their feedback using telecommunications technology, telephone contact, tribal newsletters, indigenous networks, and points of contact within tribes.

- inform Indian tribes of upcoming program announcements for which they may qualify and invite them to participate in technical assistance workshops to increase their involvement in HRSA programs.

- consult to the greatest extent practicable and to the extent permitted by law, with tribal governments and other Indian people prior to taking actions that affect them, including in the development of any program, project, conference, or other activity directed to AI/AN communities.

- foster dialogue and seek advice on practical approaches to sustain participation in decisionmaking and outreach initiatives by Indian populations. Feedback to tribes on issues for which they provided input will be an important part of this process.

- work with other OPDIVs (especially the Indian Health Service (IHS)), Federal agencies, State, local, and tribal governments to develop and support new partnerships to provide improved health care services to Indian people.

- ensure that HRSA's Strategic Plan takes into consideration the health needs of AIs/ANs.

- develop outcome and other measures as a necessary component for increasing customer satisfaction with HRSA policies and programs.

- increase efforts to recruit AIs/ANs to participate in advisory committees, grant and peer review committees, and other internal review groups within HRSA to ensure that health issues affecting AIs/ANs are considered in the planning stages of program development. Tribal governments and organizations from across the country will be invited to submit lists of recognized experts from their communities to serve on these bodies. A target goal of 5% representation will be established for these efforts.

- seek advice from AI/AN health professions groups and individuals on optimum ways to increase the number of health professionals from these populations in the workforce.

- encourage health professions schools to improve linkages with local tribes and health care providers to develop partnerships to increase the number of AI/AN health care professionals in the workforce.

- develop a network of AI/AN contacts in consultation with Indian people, members of whom will be part of HRSA's constituency lists.

- utilize the Regional Offices and HRSA's field staff as a mechanism for contacting tribes in specific areas.

- provide a single point of contact for information and outreach on HRSA programs affecting AIs/ANs in the Office of Minority Health.

Instituting initial consultation with Tribal governments and organizations from all regions on the proposed plan will take place in collaboration with the Indian Health Service, the National Indian Health Board, and other Federal agencies, and through HRSA's Field Coordinators in the regions. Information about HRSA programs will be made available on the Internet and through other sources, along with a letter from the Administrator to tribal governments, indicating his support of the consultation initiative and inviting their involvement and input on HRSA policies and programs. This letter will also be shared with health centers receiving HRSA funding. Routine government-to-government communication processes will be developed to assure that AI/AN tribes have full opportunity to participate in HRSA-supported programs as they see fit, in the same way that interface with State governments is taking place.

It is expected that the plan will be a dynamic instrument which evolves and changes as it is implemented. HRSA's consultation plan will provide a communications pathway through which on-going consultation with AI/AN leaders will occur at each stage of the process.

Included in this plan will be identification of issues for which regular consultation is desirable and a mechanism for obtaining this consultation. Throughout this process, HRSA's Strategic Plan and the relevant laws and policy concerning AIs/ANs will be the guiding documents. HRSA will explore opportunities for improved coordination and collaboration with IHS; other Federal, Regional, State, and local agencies; Tribal Councils and health departments; and national organizations representing Indian peoples as the plan is implemented and refined.

Central Point of Contact for HRSA on This Initiative:

HRSA's Office of Minority Health (OMH) will be the central point of contact for this initiative for the Agency. OMH provides leadership Agencywide for programs and activities that address the special health needs of racial/ethnic minorities,

In order to develop a consultation plan which takes into account the comprehensive issues surrounding the health care needs of Indian people, OMH will act as the coordinating point for developing this plan and work in collaboration with other offices and Bureaus to provide technical assistance and guidance in implementing its provisions.

In line with HRSA's goals and objectives related to supporting the development of comprehensive, culturally competent, family-centered, efficiently-managed community based networks of care, OMH will provide technical assistance to ensure that the health concerns of Indian people are integrated into the program development and implementation activities of the Agency within the context of overall minority health concerns. Efforts will be made to ensure
that reporting requirements are consistent with other initiatives within HRSA and that evaluation of the consultation process is conducted.

OMH will increase liaison efforts with HRSA Bureaus and offices to help the Agency recruit AI/AN and other minority representatives for HRSA advisory bodies, such as ad hoc committees, peer review committees, grant review groups, and workgroups to ensure an improved process which takes into account the health concerns of Indian populations, as identified through the consultation process.

Overall Communications Strategy:

Since successful consultation hinges on effective communication and public participation strategies, an overall communication strategy will be developed by OMH, in collaboration with the Office of Communications and OIRM and its Internet Staff, to be considered by Bureaus/offices in exploring mechanisms for consulting with AIs/ANs. One of HRSA's goals and objectives is to ensure that information technology is cost-effective and its benefits are shared by all. With this goal in mind, HRSA will utilize appropriate communication technologies available to the Agency to provide information on HRSA programs and develop a mechanism for input from Indian peoples. These strategies will include mailing consultation requests directly from a master contact list maintained by Tribes in the Office of the Secretary, as well as using available Internet capabilities, such as HRSA's Homepage and the Homepages of Bureaus/offices, and linking with systems in other Agencies such as the IHS Codetalk System, the OMH/OS Native American Health Information Service, the OMH AAIP Home Page, and other Internet networks which are targeted to reaching tribes, tribal organizations, tribal colleges and universities, private Indian organizations, national Indian organizations, state and local governments, as well as other agencies. Other technological avenues which may lend themselves to facilitating consultation include satellite teleconferencing and telemedicine systems. Telephone teleconferencing may also be a useful tool.

Other communication mechanisms that will be explored for expanding outreach, disseminating information, and gaining input on issues include meetings at the national, regional, state, and local levels with Tribal government officials as well as national groups representing Indians. Agency clearinghouses, including the Minority Health Resource Center; tribal newsletters and health information at community, migrant, and rural health centers serving Indians; and school-based health programs may also be effective avenues for disseminating information on HRSA programs and gaining tribal input. Opportunities for consulting with tribal leaders early in the development of any program, project or conference about health care services will be a particular focus.

The Role of Field Staff

HRSA Field Coordinators, and other field staff dedicated to maternal and child health programs and primary care programs related to community, rural, and migrant health centers, the homeless, the national health service corps, and other programs for special populations coordinate programs throughout states and regions. They are working on the front lines with Indian people, therefore, their input is critical in designing effective consultation mechanisms. The field computer network could be used for tribes to contact the Regional offices through E-mail to be in more direct contact with field staff. In coordination with IHS field offices, Field Coordinators will also help bring together key players with a mutual interest in enhanced consultation on HRSA issues and programs including representatives from state and local governments, public health, academia, and the private sector to address specific issues of concern to tribes in their geographic areas.

Attached are the initial cross-cutting issues identified by HRSA on which consultation could be sought. Also attached is information on Bureau/specific issues related to existing HRSA programs which can provide a communications pathway for developing improved linkages with tribes during the consultation process.

INITIAL CROSS-CUTTING ISSUES IDENTIFIED ON WHICH CONSULTATION COULD BE SOUGHT:

Criteria for identifying areas of consultation should be based on data profiling of AI/AN health status and input from AIs/ANs. A review of current HRSA data collection strategies would be useful for exploring ways to better identify issues, develop a needs assessment process, and improved outcomes measurement, since many HRSA programs do not collect sufficient data on racial/ethnic minorities served.

Several initial cross-cutting areas have been identified for consideration and consultation with Tribal governments, Indian organizations, and Indian people during plan development and implementation. They include:

Cultural Competence

HRSA is committed to the principle that health services programs must be community-driven and culturally relevant in order to be effective. For this reason, cultural competence is a critical component which is being integrated throughout the Agency into systems of care tailored to AI/AN and other minority communities. Additional efforts to train HRSA staff in cultural competency principles related to health care delivery will be undertaken.

As noted by IHS in their publication on comprehensive health care programs for AI/AN groups, the traditional beliefs of Indian people regarding wellness, sickness, and treatment are very different from the medical model or public health approach used in training health care providers today. Medical treatment provided to a person with this wellness belief system requires the consideration and integration of their beliefs with western medical practice. Because of the diverse tribal cultures within the AI/AN population, input is critical during program planning, design, and implementation. One important aspect of designing culturally competent programs for Indian people is taking into consideration the role of non-traditional Indian healers who are recognized and respected by tribes as important contributors to the health and wellness of Indian people and preservers of the culture and traditions of tribes. This is also consistent with the purposes stated in Executive Order 13021 on Tribal Colleges and Universities, one of which is to help to promote the preservation and the revitalization of AI/AN languages and cultural traditions.

Women's Health

One goal of the HRSA women's health agenda is to build the information capacity about women served by HRSA programs to determine unmet health needs. Tribal consultation would facilitate the development of this information. Use of the OWH National Women's Health Information Center to disseminate information about HRSA programs to AI/AN women and obtain feedback will be considered as one way to improve the interactive communication process needed to facilitate appropriate consultation. HRSA will explore other opportunities for enhanced consultation with AI/AN women on HRSA policies and programs affecting them.

Budget Formulation and Legislation

HRSA has no established consultation process for interacting with AIs/ANs prior to submitting the HRSA budget to the Secretary or commenting on legislative proposals affecting HRSA. HRSA participated in the Department's budget meetings with Tribal governments and organizations in 1999 and 2000. HRSA's first budget consultation meeting is in the planning stages for April 2001. Further

mechanisms can be developed on this issue after input from tribes during the first round of these discussions.

With regard to receiving input from AIs/ANs on proposed legislation affecting HRSA, HRSA's Office of Planning, Evaluation, and Legislation will identify issues on which consultation is appropriate, as they arise, and use established communication pathways identified in the Consultation Plan to obtain that input.

Managed Care

One of HRSA's goals and objectives related to managed care is to focus on working with providers and managed care organizations through community-based partnerships to assure participation of HRSA providers to promote and facilitate access to, and utilization of, appropriate services and treatment follow-up for underserved, vulnerable, and special need populations in managed care plans. In line with these objectives, HRSA will identify any issues which impact on Indian populations and assure that they are considered as opportunities for consultation during program development. Since managed care may pose access problems to AI/AN communities, there is a need for a better understanding of whether managed care has affected Indian clients at community, migrant, and rural health centers, including centers which serve Indians in urban settings, and whether managed care has affected maternal and child health and HIV/AIDS populations receiving care under the Ryan White Care Act. Consultation with leaders of organizations representing Indians served at these centers and with clients themselves can help HRSA to identify problems, if there are any, and address them.

Violence Prevention

HRSA has established the National Family and Intimate Violence Prevention Initiative to combat violence at the national level through HRSA programs. The Advisory Board established to set the parameters for the first national meeting on this initiative included AI/AN representation. The outcome of that meeting was a HRSA Action Plan to address violence prevention. The Advisory Board designing a two-part national satellite training series on combating domestic violence included Indian representation. The panels for both broadcasts included tribal representatives. As programs are developed Agencywide under this initiative, HRSA will continue to seek consultation with Tribal governments and organizations to assure that our programs effectively target Indian people.

Small and Disadvantaged Business Opportunities

Activities for increasing the involvement of AI/AN-owned businesses in HRSA's contract activities have been an on-going consideration for the Agency. HRSA has partnered with IHS in several conferences on this topic. Invitees included representatives of AI/AN-owned businesses.

BUREAU SPECIFIC ISSUES:

Although examples of Bureau-specific issues which have been identified as appropriate for consultation with Tribal governments, tribal organizations, and Indian people are listed below, along with some of the programs in place which are helping to establish improved communication between Indian people and HRSA, many other issues and programs can be identified and refined as HRSA's consultation plan is implemented.

Maternal and Child Health:

- Recognizing the need for increased consultation on issues affecting maternal and child health, HRSA has established the Office of State and Community Health (OSCH) within its Maternal and Child Health Bureau (MCHB). This office coordinates the provision of technical assistance and consultation for programs Bureau-wide, in collaboration with other MCHB Divisions, agencies, and organizations and is responsible for providing assistance to State and community health activities for funded projects such as the ones currently active in Indian communities/tribal areas. State MCH agencies cooperate with Indian communities to determine the best methods for serving mothers and children.

- The MCH Partnership for Information and Communication Interorganizational Work Group (PIC) enhances communication between HRSA and a diverse group of leaders and policy makers. PIC members undertake a wide variety of program initiatives including technical assistance, responding to information requests, and consultation to specific target audiences. HRSA will collaborate with this group to identify areas for enhanced consultation with AI/AN communities.

- Healthy Start projects have been funded with several Indian tribes in 19 reservation and Indian communities in a four-state area. Communication linkages between the project's central office and service areas consist of: monthly conference calls; quarterly meetings; mandatory training sessions; annual service area evaluations; biweekly mailings; broadcast faxes; Master serve and satellite stations (computer networking system); workgroups and individual contacts.

  This project could be utilized as a model to disseminate information and obtain greater feedback from tribes in the area. Available consultation mechanisms established through this project, including a state-of-the-art computer network, and guidance and training to project staff on case management and outreach activities, could be evaluated from the standpoint of improving consultation mechanisms with tribes and replicating successful consultation models. Since the majority of the target population is identified as IHS user population, best methods of partnership with IHS on Healthy Start projects could also be identified.

- Issues related to fetal alcohol syndrome and injury prevention among Indian populations have been identified as of special concern. HRSA participates in an Inter-agency committee on fetal alcohol syndrome and education on this issue has been part of the Healthy Start program. Increased consultation with tribes involved in the project would be beneficial, especially if funds are received for replication. HRSA has also funded, in collaboration with other OPDIVS, states, Indian tribes, and other partners the Adolescent Suicide Prevention Initiative through Regions 8 and 10. This project consults with tribes on model programs for prevention and intervention which can be used for replication. _____

Other areas where HRSA has consulted with tribes include implementation of the Children's Health Insurance Program. Linkages made with tribes as these programs are established across the country offer new routes for ongoing consultation on maternal and child health issues.

HIV/AIDS:

- HIV/AIDS is an escalating problem within Indian communities. To address this problem, HRSA has developed a partnership through its HIV/AIDS Bureau (HAB) with AI/AN tribal leaders, communities, and constituents regarding HIV services and the CARE Act that can be utilized to identify enhanced consultation models on HIV/AIDS services. Periodic consultations have enhanced the program's appreciation of the barriers and facilitators to HIV care among Indian people. The approaches developed by HRSA to meet the need for effective and relevant HIV care have consistently stressed Indian self-determination.

  Activities which have been undertaken as a result of this consultation have included: improving program guidance to reflect the epidemic within Indian nations, tribes, and communities; developing a Special Projects of National Significance (SPNS) initiative that identified and funded innovative projects delivering HIV services to Indian people living with HIV; and funding a national evaluation of these projects. Currently, HRSA is implementing the reauthorized CARE Act with revisions that direct the SPNS program to include projects that "ensure the ongoing availability of services for Native American communities to enable such communities to care for Native Americans with HIV disease." Consultation with tribes is an integral part of these SPNS programs and provides models for enhancing consultation activities on HIV/AIDS.

  Other HIV/AIDS activities conducted with AI/AN consultation and participation have included: conducting a work group on barriers to HIV care, composed of 20 AI/AN people living with HIV: women, men, service providers, researchers, and activists. They provided accounts of barriers to HIV care, described strategies to reduce barriers, and made recommendations for improving access to Federal HIV services.

  A basis for enhanced consultation with representatives of the Navajo Nation was established when HRSA received a tribal delegation. Issues surrounding the Federal response to HIV within the Navajo Nation were discussed, and HRSA staff were invited to visit and learn about local conditions. Included in this visit were additional visits to five Indian nations in Arizona and New Mexico. Tribal leaders, local health providers, and people living with HIV discussed service delivery issues and their recommendations. This consultation pathway can be utilized to identify ways to build on these established relationships and develop additional opportunities for consultation.

Organ Donation:

- The percentage of organ donations by members of AI/AN communities is low. Improved consultation mechanisms established with Indians may provide a communications pathway to discuss issues related to organ transplantation and develop culturally competent programs which may increase organ donations from Indian people.

Health Professions Workforce Development

In line with HRSA's goals and objectives to increase the number of underrepresented minorities and disadvantaged individuals going into the health professions, to reflect more closely the ethnic and racial diversity of target populations, HRSA will work with other Federal agencies, Regions, States, Tribal governments, and academia to promote training and education programs to ensure that the current and future workforce has the skills and capacities to meet health care needs.

- Increasing the number of underrepresented minorities, including Indians, in the health care workforce has been identified as a severe problem. Several programs within HRSA's Bureau of Health Professions (BHPr) are geared to increasing the number of underrepresented minorities in the health professions. They include the Centers of Excellence (COE) in Minority Health Professions Education program; the Health Career Opportunities program, which educates minorities in the health professions; and programs for disadvantaged students in the health professions. AI/AN students are eligible for these programs.

  COEs serving AIs/ANs were funded in FY 2000 at the University of Oklahoma Health Sciences Center, the University of Washington School of Medicine, and the University of Minnesota School of Medicine. In line with the President's Executive Order 13021 on Tribal Colleges and Universities, HRSA will be examining ways of expanding access to Federal resources for tribal colleges and universities. Consultation with the American Indian Higher Education Consortium, which represents tribal colleges and universities at the national level, has been developed as one of the first steps in the consultation plan to determine how best to address health professions education issues related to AIs/ANs. Other linkages with institutions of higher education are underway.

- Issues related to creating an educational pipeline which can carry students through grade school, high school, college, and into health professions training have been identified as a problem for minority groups, including Indians. As a result, models for supporting efforts to encourage minority youth to pursue careers in the sciences and math, leading to health professions careers, are being developed for minority populations. Consultation with AI/AN groups on pipeline issues can help HRSA to develop more effective programs under the new Executive Order. These consultations will take place at the national, regional, state, and local levels. Opportunities for supporting these efforts will be explored as HRSA implements the provisions of the order. An additional effort that has been initiated is a Native American Summer Youth Initiative which brings students into the Agency to encourage them to enter health professions careers.

- Development of curricula which train health professionals to deliver culturally competent care to AI/AN populations is an identified need. AI/AN faculty development is an integral component of this effort to appropriately train health care professionals to serve Indian people. These issues would benefit from consultation with AI/AN groups representing the tribal colleges and universities and other institutions of higher education which serve AIs/ANs as well as with organizations representing AI/AN health professionals.

<u>HRSA's Role in Delivering Primary Health Care to AI/AN Populations</u>:

Although IHS has major responsibility for the delivery of primary health care to Indian people, HRSA is involved in this issue through a variety of programs as a partner. Examples of these programs are outlined below.

- Through its Bureau of Primary Health Care (BPHC), Urban Indian Health Programs which are Federally Qualified Health Centers are eligible to receive funds. Three Centers currently receive funds. Other HRSA community, rural, and migrant health centers also serve AI/AN populations. HRSA will identify opportunities within these centers for providing information about programs for which AIs/ANs may be eligible, as well as identify health care issues of concern to AI/AN populations which would benefit from consultation.

  BPHC recently funded a Healthy Schools/Healthy Communities program on the Leech Lake reservation. This project will expand activities in the school clinic to include outreach into the community. Projects under this program reach directly into Indian communities and provide additional avenues for building on established linkages with Tribal governments.

- Other consultation mechanisms that can be put in place with Tribal governments to enhance HRSA's work in the delivery of integrated, culturally competent health care include representation on committees and workgroups dealing with issues such as cultural competence, the impact of Medicaid and managed care reform on HRSA clients, and other primary care delivery issues. Consultation will also be sought on the placement of Indian providers in high impact underserved areas, e.g., urban Indian communities. In response to HRSA's goals to improve the ability to measure unmet needs of HRSA target populations for health care services, training, and other interventions, consultation will be sought with AIs/ANs in the design of evaluation tools to assess health outcomes for AIs/ANs served by HRSA health delivery programs.

STATUTES AND POLICIES APPLICABLE TO TRIBAL CONSULTATION ACTIVITIES

I. Introduction

The United States government and the governments of American Indians and Alaska Natives (AI/AN or Indian people) have a "government-to-government" relationship based on the U.S. Constitution, treaties, Federal Statutes, court decisions, and Executive Branch policies, as well as moral and ethical considerations. This special relationship also constitutes a trust relationship between these two governments. Certain benefits provided to Indian people through Federal legislatively enacted programs flow from this trust relationship. These benefits are not based upon race, but rather, are derived from the government-to-government relationship. A vital component of this relationship is consultation between the Federal and tribal governments. In cases where the government-to -government relationship does not exist, as with urban Indian centers, Inter-tribal organizations, state-recognized tribal groups, and other Indian organizations, consultation is encouraged to the extent that there is not a conflict-of-interest in the above stated Federal statutes or the Operating Division/Staff Division (OPDIV/STAFFDIV) authorizing legislation. Some aspects of this consultation are set out in statute and administrative policy.

II. Foundations

A. Federally Recognized Tribes and Organizations

The special relationship between the U.S. government and tribal governments is grounded in many historical, political, legal, moral, and ethical considerations. Increasingly, this special relationship has emphasized self-determination for Indian people and meaningful involvement by Indian people in Federal decision making (consultation) where such decisions affect Indian people or otherwise. Consultation examples include:

1. A provision in the Indian Self-Determination and Education Assistance Act, P.L 93-638, as amended, codified at 25 U.S.C. 450a states that:

   "(a) Congress . . . recognizes the obligation of the United States to respond to the strong expression of the Indian people for self-determination by assuring maximum Indian participation in the direction of . . . Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities."

   "(b) The Congress declares its commitment to the maintenance of the Federal Government's unique and continuing relationship with, and responsibility to, individual Indian tribes and Indian people as a whole through . . . effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services."

2. Regulations implementing the Indian Self-Determination Act, as amended, contain the following provisions:

> 25 C.F.R. 900.3(a)(2): " Congress has declared its commitment to the maintenance of the Federal Government's unique and continuing relationship with, and responsibility to, individual Indian tribes and to the Indian people as a whole through the establishment of meaningful Indian self-determination policy which will permit an orderly transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services . . . ."
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> 25 C.F.R. 900.3(b)(1): "It is the policy of the Secretary to facilitate the effort of Indian tribes and tribal organizations to plan, conduct, and administer programs, functions, services and activities, or portions thereof, which the Departments are authorized to administer for the benefit of Indians because of their status as Indians . . . ."

3. The Indian Health Care Improvement Act, P.L. 94-437, contains a "Congressional Finding [ ]," codified at 25 U.S.C. 1601, that:

> "(b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services."

4. The Unfunded Mandates Reform Act of 1995, P.L. 104-4 states:

> Section 2. "The purposes of this Act are . . . to assist Federal agencies in their consideration of proposed regulations affecting . . . Tribal governments by . . . requiring that Federal agencies develop a process to enable . . . Tribal governments to provide input when Federal agencies are developing regulations; and requiring that Federal agencies prepare and consider the budgetary impact of Federal regulations containing Federal mandates upon . . . Tribal governments before adopting such regulations."

5. The President's Memorandum of April 29, 1994, to Heads of Executive Departments and Agencies titled, "Government-to-Government Relationship with Native American Tribal Governments." This memorandum outlines the key concepts of consultation.

B. Non-Federally Recognized Tribes and Other Indian People

Indian people are often significantly or differentially affected by the Department of Health and Human Services (HHS) actions, may have special needs that HHS policy makers may not be sensitive to, may make especially valuable contributions to policy formulation and program administration because of their unique perspectives, and may be expressly mentioned in HHS statutes, or need to be effectively and efficiently served as a part of the HHS' mission.

Although the special "tribal-federal" relationship is based in part on the government-to- government relationship, other statutes and policies exist that allow for consultation with non-federally recognized tribes and other Indian organizations that, by the mere nature of their business, serve Indian people and might be negatively affected if excluded from the consultation process.

1. A statute administered by the Indian Health Service (IHS), 25 U.S.C. 1653, requires the Secretary of HHS to enter into contracts with or issue grants to urban Indian organizations to assist such urban centers for the provision of health care and referral services for urban Indians residing in the urban centers in which such organizations are situated. (42 U.S.C. 1654 authorizes grants and contracts with urban Indian organizations to determine the health status and unmet health needs of urban Indians).

2. A statute administered by the Administration for Native Americans (ANA), Sec. 802. [42 U.S.C. 2991b] provides financial assistance for Native American projects, including but not limited to, governing bodies of Indian tribes on Federal and State reservations, Alaska Native villages and regional corporations established by the Alaska Native Claims Settlement Act, and such public and nonprofit agencies serving Native Hawaiian, and Indian and Alaska Native organizations in urban and rural areas that are not Indian reservations or Alaska Native Villages, for projects pertaining to the purpose of this title. The Commissioner is authorized to provide financial assistance to public and nonprofit private agencies serving other Native American Pacific Islanders (including American Samoan Natives) for projects pertaining to the purposes of this act. In determining the projects to be assisted under this title, the Commissioner shall consult with other Federal agencies for the purposes of eliminating duplication or conflict among similar activities or projects and for the purpose of determining whether the findings resulting from those projects may be incorporated into one or more programs for which those agencies are responsible. Every determination made with respect to a request for financial assistance under this section shall be made without regard to whether the agency making such request serves, or the project to be assisted is for the benefit of, Indians who are not members of a federally-recognized tribe. . . ." The statute (42 U.S.C. 2991b-2(c)(2)) also requires that the ANA Commissioner "serve as an effective and visible advocate for Native Americans . . .;" while 42 U.S.C. 2991b-2(d) establishes, in the Office of the Secretary, the Intra-Departmental Council on Native American Affairs. Among its responsibilities, 42 U.S.C. 2991b-2(c)(3) requires that this Council assist the Commissioner in "coordinating activities within the Department leading to the development of policies, programs, and budgets, and their administration that directly affect Indian and other Native populations. . . "

3. A statute administered by the Administration for Children and Families that establishes the Low Income Home Energy Assistance Program (42 U.S.C. 8621 et seq.) and its implementing regulations (45 C.F.R. 96.48) make clear that Federal and state recognized tribes may receive direct funding under this block grant.

4. A statute administered by the Health Resources and Services Administration that establishes the Centers of Excellence in Minority Health Program (42 U.S.C. 293c(c)(4), (d)(3), (e)) provides for funding of programs of health professions education at Native American Centers of Excellence.

Other HHS components that rely on more general statutory consultation language also conduct activities that directly affect Indian people.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE
ROCKVILLE, MARYLAND 20857

Refer to: OD/OTP

INDIAN HEALTH SERVICE CIRCULAR NO. 97-07

TRIBAL CONSULTATION AND PARTICIPATION POLICY

Sec.

1. PURPOSE. The Indian Health Service (IHS), together with American Indian and Alaska Native (AI/AN) tribal governments and organizations, hereby establishes this policy requiring consultation and participation by and between these governments on IHS program policies and activities.

2. BACKGROUND. A unique government-to-government relationship exists between AI/AN tribes and the Federal government. Treaties and laws, together with court decisions, have defined a relationship between the AI/AN people and the Federal Government that is unlike that between the Federal Government and any other group of Americans. The implementation of this policy is in recognition of this special relationship.

3. PHILOSOPHY. This policy is based on the following two foundations.

A. Political/Legal Foundations.

(1)The Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638, as amended, states:

Section 3(a): *"Congress...recognizes the obligation of the United States to respond to the strong expression of the Indian people for self-determination by assuring maximum*

Indian participation in the direction of...Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities."

Section 3(b): *"The Congress declares its commitment to the maintenance of the Federal Government's unique and continuing relationship with, and responsibility to, individual Indian tribes and Indian people through...effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services."*

(2)"The Indian Health Care Improvement Act, P.L. 94-437, as amended, states:

Section 2(b): *"A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services."*

(3)"Memorandum to the Heads of Executive Departments and Agencies from President William J. Clinton, April 29, 1994, states:

(b) "Each executive department and agency shall consult, to the greatest extent practicable and to the extent permitted by law, with tribal governments prior to taking actions that affect federally recognized tribal governments. All such consultations are to be open and candid so that all interested parties may evaluate for themselves the potential impact of relevant proposals."

B. Ethical Foundation. The ethical foundation of this policy is the special relationship between sovereign governments; the United States and AI/AN tribal governments. This relationship is based on the cession of lands by AI/AN tribes in return for the provision of services by the United States. The AI/AN people have an inalienable right to self-government. Self-government means government in which decisions are made by the people who are most directly affected by the decisions. The United States has a moral obligation to promote consultation and participation with AI/AN tribal governments.

4. DEFINITIONS.

A. Consultation. Consultation is an enhanced form of communication that emphasizes trust and respect. It is a shared responsibility that allows an open and free exchange of information and opinion among parties that leads to mutual understanding and comprehension. Consultation is integral to a process of mutually satisfying deliberations to result in collaboration and joint decision-making.

B. Participation. Participation is effective, mutually satisfactory, joint decision-making. In true participation, an individual is not required to endorse or accept unilateral decisions made by either party.

5. OBJECTIVES.

A. To formalize the requirement for consultation and participation by representatives of tribal governments in IHS policy development and program activities.

B. To establish a minimum set of requirements and expectations with respect to consultation and participation for the three levels of IHS management: Headquarters, Area Offices, and Service Units.

C. To identify critical events at which tribal consultation and participation will be required for the three levels of IHS management: Headquarters, Area Offices, and Service Units.

D. To promote the development of innovative methods of obtaining consultation on issues from tribal representatives and involving representatives in Agency decision making processes.

E. To charge and hold responsible the principal managers within the IHS (the Director, Deputy Director, Chief Medical Officer, Director of Headquarters Operations, Director of Field Operations, Senior Advisor to the Director, Area Directors, Headquarters Office Directors, and Service Unit Directors) for the implementation of this policy.

6. ESTABLISHMENT OF TRIBAL ADVISORY ORGANIZATIONS/COMMITTEES.

The principal focus for consultation and participation activities of the IHS is with individual tribal governments. However, it is frequently necessary that the IHS have organizations/committees in place from which to solicit consensual tribal advice and recommendations, and to involve tribes in decision-making and policy development.

In consultation with elected tribal governments, the IHS identifies and assists in the support of tribal health advisory organizations/committees.

A. Headquarters. The National Indian Health Board (NIHB) serves as the advisory organization and a major source of consultation and advice on issues of national importance. Support for the NIHB is negotiated by the Director, IHS, and the Board of Directors of the NIHB. Meetings between IHS management and the Board of Directors of the NIHB are scheduled on a quarterly basis.

B. Area Offices. Each Area Director, in consultation with tribal governments, must designate an organization/committee representative of all tribal governments served by the Area Office. The designated organization shall provide advice and consultation to the Area Director and Area office staff. Meetings between the designated tribal organization and Area Office management and staff shall occur at least four times each year. In lieu of establishing a formal organization/committee, Area Directors provide funding for travel and per diem to enable representatives of tribal governments to meet with the Area Director and the executive management staff in the Area on a regular basis (at least quarterly).

C. Service Units. The Health Advisory Board established at each IHS service unit is the organization utilized by the Service Unit Directors (SUD) and management/ clinical staff for regular consultation and participation purposes. Each SUD and his/her staff meets with tribal government officials (e.g., chairperson, tribal council on a mutually agreed to schedule).

7. SCHEDULE FOR CONSULTATION. Managers in the IHS must establish and adhere to a formal schedule of meetings to consult with tribal governments and representatives concerning the planning, conduct, and administration of IHS activities. Trust between the IHS and tribal governments and organizations is an indispensable element in establishing a good consultative relationship. Managers in

the IHS must involve tribal representatives in meetings at every practicable opportunity.

The IHS managers are encouraged to establish additional forums for tribal consultation and participation, and for information sharing with tribal leadership.

8. IHS BUDGET.

A. Budget Formulation. The IHS managers are to solicit the active participation of tribes and tribal organizations in the formulation of the President's proposed budget for the IHS. The formulation of the President's budget involves the three levels of IHS management and requires tribal consultation and participation at each level.

(1) Service Unit. Each SUD is responsible for meeting with tribes on an annual basis to ensure the tribes' participation in the budget formulation process and in identifying budget priorities.

(2) Area Office. An Area-wide budget formulation team shall be established and composed of tribal representatives and appropriate IHS staff. The Area team is responsible for identifying Area-wide health priorities and budget priorities, within the parameters and guidelines provided by the Office of Management and Budget. Each Area team provides input at every major stage of the budget formulation process, including briefing the Area Board Representatives to the NIHB.

(3) Headquarters. The Director, IHS, and a Headquarters budget formulation team composed of Senior staff, utilizes the recommendations of the Area teams to propose the annual IHS budget for submission to the Assistant Secretary for Management and Budget. Subsequent to the submission of the proposed IHS budget, the Director consults with tribal representatives to review health priorities and budget priorities at each stage of the budget formulation process.

B. Budget Execution. It is IHS policy to involve tribal governments in decision-making concerning the allocation of new funding (i.e., funding that is not base funding to a tribe or congressionally earmarked for specific tribes) this is provided as a result of the appropriations process. This policy is described in IHS Circular No. 92-5, "Budget Execution Policy (Allocation of Resources)."

The appropriate consultative organizations for this purpose are described in Section D. of this Circular, or may be any other organizations or mechanisms as agreed to by the Area Director and tribal governments.

C. Budget Information Disclosure. The IHS managers must initiate a process whereby the tribes and tribal organizations are provided the following IHS budget related information on an annual basis: appropriations, allocation, expenditures, and funding levels for programs, functions, services, and activities.

9. CRITICAL PERFORMANCE ELEMENT. A critical performance element requiring the implementation of this policy shall be made part of the annual performance standards of principal managers in the IHS.

10. TRIBAL RESOLUTIONS. Resolutions submitted by tribal governments to the IHS shall be referred to the appropriate IHS program office. The receipt of tribal resolutions shall be formally acknowledged by the IHS to the tribal

government/organization. A substantive response, if required, must be forwarded to the tribal government within sixty days.

11. EFFECTIVE DATE. This circular is effective on the date of signature by the Director, IHS.

/s/ Michael H. Trujillo, M.D.

Michael H. Trujillo, M.D., M.P.H., M.S.
Assistant Surgeon General
Director, Indian Health Service

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FRAMEWORK FOR A TRIBAL CONSULTATION PLAN
National Institutes of Health

BACKGROUND

On April 29, 1994, President Clinton issued an Executive Memorandum addressing government-to-government relations with American Indian and Alaskan Native (AI/AN) tribal governments. The Memorandum directed that each Department "consult, to the greatest extent practicable and to the extent permitted by law, with tribal governments prior to taking actions that affect federally recognized tribal governments." Additionally, the President issued Executive Order No. 13084, "Consultation and Coordination with Indian Tribal Governments in November 2000. This Order revoked a previous order on the same subject, reiterated the unique government-to-government relationship between the Federal government and tribal governments, and placed particular emphasis the right of tribal self-governance. The order directed that each Federal agency develop a process to ensure "meaningful and timely" input by tribal officials in the development of regulatory and other policies that have "Substantial direct effects" on one or more tribes or the relationship between the Federal Government and tribes.

THE PROPOSED PROCESS

The NIH embraces the Indian Health Service's concept of consultation. The IHS defines consultation as an "enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in mutually satisfying collaboration and decision making."

With this in mind, the recently established National Center on Minority Health and Health Disparities will take the lead in developing the NIH Tribal Consultation Plan in consultation with the NIH Director, the NIH Institutes and Centers, and with Tribal representatives. This delegation of responsibility to the Center director is supported in statute.

P.L.106-525 states that the Director of the Center "shall represent the NIH as the Primary Federal official [with respect to] the health disparities research program of the National Institutes of Health, [and] shall represent the NIH at all relevant Executive branch task forces, committees and planning activities; and shall maintain communications [concerning advances in minority health disparities research] with all relevant Public Health Service agencies, including the Indian Health Service, and various other departments of the Federal Government Y."

In addition, the public law (P.L.106-525) states "the Secretary shall establish an advisory council to advise, assist, consult with, and make recommendations to the Director of the Center... A majority of the members shall be individuals with demonstrated expertise regarding minority health disparity and other health disparity issues; representatives of communities impacted by health disparities shall be included; and a diversity of health professionals shall be represented." When acting in an advisory capacity, council members are temporary employees of the Federal Government. Accordingly, it is proposed that Center's advisory council membership play a key role in the NIH tribal consultation process.

Following the example of the model used to initiate the Departments Communication Plan for I-131--a plan to inform the American public about the health impacts of Iodine-131--the Center proposes to sponsor a Consultation Workshop to obtain input from the Native American Community, NIH Institutes and Centers and Centers, and the Advisory Council regarding the best way to carry out the consultation process. The second step will be to form a Tribal Consultation Development Group, chaired by the NCMHD director or his designee, to draft the Tribal Consultation Plan.

And finally, since the public law that established the new Center (P.L. 106-525) directed, among other things, that the trans-NIH strategic plan serve as a broad, binding statement of policies with regard to health disparity related activities, it seemed appropriate that the final Tribal Consultation plan be included in the Trans-NIH Strategic Plan for Reducing Health Disparities. The target completion date for the Tribal Consultation Plan would coincide with the completion date for the strategic plan--the law requires that the strategic plan be completed no later than December 2001.

THE ROLE OF THE NIH WITH RESPECT TO HEALTH - Potential Areas for Consultation

The intent of this section of the framework document is to distinguish the role that the NIH plays, with respect to health, from that of the other agencies within the Department. Areas of discussion include the NIH mission, the mechanisms for achieving its mission, and priority setting. The aim is to assist the tribes in identifying potential areas for consultation. However, based on the Presidential directive that Federal agencies "consult on those policies that have substantial direct effects on one or more tribes" the NIH anticipates that potential areas for consultation will likely include the following: expanded program development with respect to increasing opportunities for Native American participation in research, training, and access to NIH support.

The Mission

The NIH mission is to uncover new knowledge that will lead to better health for everyone. Its goal is to discover new knowledge that can help to prevent, detect, diagnose, and treat disease and disability, from genetic disorders to the common cold. The agency facilitates the discovery of new knowledge through the investment of tax dollars for the support and conduct of biomedical and biobehavioral research. With respect to minority health and other health disparities, the goal of the NIH is to support research to understand the epidemiology of disease and disability, to determine their causes, and to develop innovative diagnostics, treatments, and preventive strategies to address health disparities.

Achieving the Mission

The NIH achieves its mission by conducting research in its own laboratories; supporting research in universities, medical schools, hospitals, and research institutions throughout the country and abroad; assisting in the training of research investigators; and fostering the communication of medical information. Approximately 82 percent of NIH's investments are made through its Extramural Research Program, a broad base program of basic and clinical research, which is accomplished through a system of grants and contracts supporting research and training in more than 2,000 research institutions throughout the U.S. and abroad.

The **Research Project Grant** (or RPG), the primary vehicle of the extramural program, usually supports a single project and a single principal scientist. The research project begins with an idea of an individual scientist that can range from medical research, molecular and cellular investigations, to studies of new drugs to treat human illness. The project might be small, or it might involve millions of dollars. The project might become useful immediately as a diagnostic test or new treatment, or it might involve studies of basic biological processes whose practical value may not be apparent for many years.

Other types of grant mechanisms include the **program project grant** and the **center grant**. Program project grants support several investigators working on several projects, each of which focuses on different aspects of a research problem. Center grants are awarded to research institutions under the leadership of a center director and a group of collaborating investigators. Center grants fund medical research programs that span several disciplines or subject areas/fields. These grants also support the development or purchase of research resources for the purpose of facilitating the integration of basic research with applied research

and for promoting research on clinical applications. Research resources include human resources (e.g., support for investigators), animal, technological and other resources (e.g., funds for research support, etc.).

The **research and development contract**, the fourth vehicle used by the NIH to accomplish its mission, is awarded to non-profit and commercial organizations for work requested and overseen by the NIH staff. For example, development of the drug taxol for treating breast and ovarian cancer was accomplished through NIH contracts. The nature of these contracts ranged from requests for the development of better methods for isolating the anti-cancer agent from the Pacific yew tree to conducting clinical trials to test its effectiveness.

The Grant Application Process

Each grant application is evaluated for scientific merit using the peer review process. A panel of scientific experts, primarily from outside the government, who are active and productive researchers in the biomedical sciences, evaluates the scientific merit of the application. Scientific merit is determined from an overall assessment of the following areas with respect to the research proposal:

- Significance: The extent to which the project, if successfully carried out, will make an original and important contribution to biomedical and/or behavioral science.

- Approach: The extent to which the conceptual framework, design (including as applicable, the selection of appropriate subject populations or animal models), methods, and analyses are properly developed, well integrated, and appropriate to the aims of the project.

- Feasibility: The likelihood that the proposed work can be accomplished by the investigators, given their documented experience and expertise, past accomplishments in research, preliminary data, requested and available resources, institutional commitment, and (if appropriate) documented access to special reagents or technologies and adequacy of plans for the recruitment and retention of subjects.

After the initial review and scoring of the proposal, a national advisory council or board, comprised of eminent scientists as well as public members who are interested in health issues or the biomedical sciences, determines the project's overall merit and priority, with respect to the priorities of the potential funding institute, and recommends consideration for funding. Actual funding decisions are made by the potential funding institute or center (IC) based on overall scientific merit, available funding, and the extent to which the proposed research can advance the mission of the funding IC.

Setting Priorities for Health Research

A number of criteria are used to prioritize research investments.

- The number of people who have a particular disease;
- The number of deaths caused by a disease,
- The degree of disability produced by a disease;
- The degree to which a disease cuts short a normal, productive, comfortable lifetime;
- The economic and social costs of a disease; and
- The need to act rapidly to control the spread of a disease.

While the NIH focuses much of its research on combating specific diseases, the NIH also places a high priority on funding basic research. By supporting disease-related and basic research projects simultaneously, the NIH can achieve both near-term improvements in the diagnosis, treatment, and prevention of specific diseases as well as long term discoveries in basic science that in time will produce great advances in our ability to understand, treat, and prevent disease or delay its onset.

Disparities in Health Status
While the diversity of the American population is one of the Nation=s greatest assets, one of our greatest challenges is reducing the profound disparity in health status between America=s racial and ethnic minorities, including Native Americans; Appalachian residents; and other similar groups compared to the population as a whole. And although some of the causes of disparate health outcomes, such as differences in access to care, are beyond the scope of biomedical and bio-behavioral research, the NIH can play a vital role in addressing and easing health disparities involving cancer, diabetes, infant mortality, AIDS, cardiovascular illnesses, and many other diseases. Accordingly, the NIH has made health disparities, including minority health, a budget priority and an area of emphasis.

Establishing the National Center on Minority Health and Health Disparities
Although health disparities became a special emphasis area at the NIH, still, additional authorities with sufficient resources were needed for the purpose of program planning and coordinating the minority health disparities research and other health disparities research programs of the NIH Institutes and Centers. The NIH is also seeking to improve the visibility of minority health disparities research and other health disparities research as well as expand their roles in providing new knowledge aimed at eradicating and/or easing disparities in health status.
Toward that end, new legislation has authorized the establishment of the National Center on Minority Health and Health Disparities (NCMHD) within the NIH. This change will assist in the development of an integrated national health research agenda reflecting the current and emerging health needs of racial and ethnic minorities and other populations with health disparities.

This change will also promote and facilitate the creation of a robust environment for minority health disparities research an other health disparities research environment with sustained funding for a wide range of studies—basic, clinical, and behavioral, population research; studies on the influences of processes by which health is maintained or improved; and research on the societal, cultural, and environmental dimensions of health--all aimed at identifying potential risk factors associated with disparate health outcomes.

Native American Health

The health problems facing Native Americans are immense, for example:

- The Native American population, including American Indians and Alaska Natives, totals nearly 1.5 million from over 500 tribes and nearly 300 reservations and Alaska Native villages. Earlier in this century, heart disease was rarely noted in Native Americans, but in the last decade cardiovascular disease has become the leading cause of death in Native Americans. Several factors may be responsible for this increase: a decreasing incidence of infectious disease, an increasing incidence of diabetes mellitus, and an increasing incidence of obesity. [Adapted from an NHLBI Request for Applications.)

- Fifty percent of Pima Indians over age 35 have type-2 diabetes; the highest rate in the world; and it is speculated that genetic differences are one cause of the disproportionate prevalence of both diabetes and the end stage renal disease (ESRD) that often develops from long-term diabetes. This finding is the latest in a series of insights on the epidemic of type 2 diabetes and its complications uncovered by scientists from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) who work with Pima Indian volunteers at the Gila River Indian Community near Phoenix. [NIDDK News Release]

- Although American Indians and Alaska Natives continue to experience low cancer incidence rates in comparison with other racial groups such as whites, blacks, and Asians, within the last few generations, cancer has become the leading cause of death for Alaska Native women, and is the second leading cause of death between both American Indian and Native Hawaiian women. (Department of Health and Human Services, HIS Trends, 1992, p. 34, IHS, Cancer Mortality, 1992.)

- Data on health disparities between Native Americans and the US population as a whole indicate thatYthe incidence of alcoholism is 627 percent greater; tuberculosis is 533 percent greater, and diabetes at least 250 percent greater. [IC Director= Meeting Highlights B September 14, 2000]

Dr. Trujillo, the first IHS Director appointed by the President and confirmed by the Senate, Anoted during his first trip to the NIH Ait will be very difficult to address these disparities unless there is a different funding paradigm.

Existing Outreach to the Native American Community

A number of the NIH institutes and Centers have ongoing initiatives with the Native American community. While the initiatives will not be described in framework document, the ICs that have ongoing initiatives with the Native American community include: The National Institute of General Medical Sciences, the National Human Genome Research Institute, the National Institute on Drug Abuse, the National Institute of Diabetes and Digestive and Kidney Diseases, the National Institute of Dental and Craniofacial Research, and the National Cancer Institute.

GUIDING PRINCIPLES FOR TRIBAL CONSULTATION

Tribal consultation is a priority for the NIH.

- Within the framework of the strategic planning process, the Federally recognized tribes would be afforded the opportunity to provide input into the strategic plan through a process to be determined. Accordingly, the tribes would have an opportunity to ensure that their priorities, within the context of the NIH mission, are addressed in the near and long term goals and objectives of the trans-NIH strategic plan.

- In addition to consulting with the NIH through the strategic planning process, consultation can also take place using a variety of other methods, including but not limited to: 1) input through the Native American membership on the NCMHD Advisory Council B Tribal leaders would be advised annually of the Advisory Council membership and its meeting dates; and 2) participation in Subcommittee meetings of the Advisory Council which could be held periodically at mutually agreed upon locations, etc.).

Communities can be empowered to contribute in a meaningful way toward improving and eliminating disparities in health status.

- Under the aegis of the Department=s Initiative to Eliminate Health Disparities, the NIH would seek to design programs aimed at empowering Native American and other health disparity communities to contribute to in a meaningful way toward reducing and eliminating disparities in health status. Accordingly, the strengths of Tribal Colleges and Universities from the perspective of the Native American community is an important consideration in identifying the potential roles these institutions might effectively play, within the context of the NIH mission, in addressing Native American health disparities issues.

Improved access to NIH support through improved policy development is a priority at NIH.

While the NIH mission is incompatible with the concept of using formula driven processes to achieve "equitable funding across all populations," the agency is committed to examining current policies that appear to have disparate impact, with respect to the ability of Native Americans and other ethnic and racial minority populations, to access NIH funding support for health research and training and related activities.

One of the barriers to access to NIH support for some special population groups resides in the area of policy development. The NIH is committed to increasing its efforts in developing policies that serve to "level playing field." The concept of a level playing field embraces the idea that only institutions with similar research infrastructure, strengths, and missions should compete for the same pool of funds. The focus is not on set asides but rather on identifying policies with disparate impact.

In his presentation to the NIH Institute and Center directors, the director of the Office of Civil Rights, Mr. Tom Perez, indicated that the identification of policies that, while appearing neutral, have a disparate impact on opportunities for participation in programs is a area of emphasis for the Department and its operational divisions. (The NIH is an operational division of the Department of Health and Human Services.)

Substance Abuse and Mental Health Services Administration
Tribal Consultation Plan

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA), an Operating Division of the Department of Health and Human Services (HHS), has a well established track record in working with American Indian and Alaska Native (AI/AN) populations, including close collaboration with the Indian Health Service (IHS).

SAMHSA, the successor to the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) was established by legislation, P.L. 102-321, on July 10, 1992. The 1992 legislative mandate established three entities within SAMHSA, the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the
Center for Substance Abuse Treatment (CSAT).

SAMHSA's mission is "to improve the quality and availability of prevention, treatment and rehabilitation services in order to reduce illness, death, disability and cost to society resulting from substance abuse and mental illnesses". Working for and with American Indian and Alaska Native communities has always been an integral part of SAMHSA's mission and practices. Most of SAMHSA's AI/AN efforts have been with community based organizations and National organizations, such as the National Association for Native American Children of Alcoholics (NANACOA). Although past consultative processes have been ad hoc and related to specific projects, during the development of the SAMHSA Strategic Action Plan, SAMHSA widely and formally reached out to communities throughout the Nation.

Background

This plan is designed to satisfy the mission of SAMHSA with respect to American Indians and Alaska Natives and to comply with the following Legislative and Executive Branch mandates:

- The Indian Self-Determination and Education Assistance Act, P.L. 93-638, Section 3(a) "Congress ... recognizes the obligation of the United States to respond to the strong expression of the Indian people for self-determination by assuring maximum Indian participation in the direction of ... Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities."

- The Indian Health Care Improvement Act, P.L. 94-437, Section 2(b) "A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services."

- Memorandum for the Heads of Executive Departments and Agencies from President Clinton, April 29, 1994, states: "Each executive department and agency shall consult, to the greatest extent practicable and to the extent permitted by law, with tribal governments prior to taking action that affects federally recognized tribal governments. All such consultations are to be open and candid so that all interested parties may evaluate for themselves the potential impact of relevant proposals."

- Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, November 6, 2000 (supercedes Executive Order 13084 of the same title), provides instructions to agencies related to their policymaking, legislative and regulatory activities, and states: "Agencies shall respect Indian tribal self-government and sovereignty, honor tribal treaty and other rights, and strive to meet the responsibilities that arise from the unique legal relationship between the Federal Government and Indian tribal governments."

Over the past years, SAMHSA has carried out consultations with tribal communities on an ad hoc, informal basis. For example, SAMHSA has many activities and programs involving tribal communities and routinely consults with the Agency's American Indian/Alaska Native grantees. However, when the new SAMHSA organization was established in 1992, SAMHSA formally consulted with AI/ANs, through focus groups, on the development of the SAMHSA Strategic Action Plan.

The SAMHSA Tribal Consultation Plan outlined here adheres to the guidance provided by the Domestic Policy Council Working Group on Indian Affairs.

Guiding Principles

SAMHSA's Plan is based on the following definition of consultation proposed by the Departmental Work Group on American Indian Consultation: "Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process which results in mutually satisfying collaboration and decision making."

A major underpinning of SAMHSA's Plan is that there is a special relationship between the government of the United States and tribal governments which is grounded in many historical, political, legal, moral, and ethical considerations. Although this Plan is not confined to consultation with Federally recognized tribes alone, it recognizes and respects the government-to-government level of the consultation.

While this Plan puts in place a formal consultation process, it continues to encourage use of the very effective personal and ad hoc communications that have served SAMHSA well in the past. The Plan's goal is to expand SAMHSA's communication circle with tribal governments and communities.

SAMHSA's Tribal Consultation Plan

Consultation between SAMHSA and tribal governments cannot and should not be limited to one or a few strictly defined pathways but must be both flexible and structured. Further, the consultation process will be specifically related to the work and mission of SAMHSA which is to improve the quality of substance abuse prevention and treatment and mental health services. Although SAMHSA has engaged in much dialogue with American Indians and Alaska Natives over many issues, there continues to be the need for more discussions about the best mechanisms for facilitating consultation. SAMHSA will seek guidance and participation of tribal governments in consulting about existing and planned activities and projects. SAMHSA is committed to including tribal government leaders and their staff in discussions about issues, concerns and priorities pertaining to substance abuse and mental health related activities.

Methodology

With the agreement of tribal governments, SAMHSA's Consultation Plan should establish a communication strategy with the following characteristics:

- A mutually agreed upon, prioritized list of specific issues or areas should be developed;
- The timing of the consultation should be such that tribal recommendations can be considered in SAMHSA's decision making processes;
- The communication channels established should be mutually acceptable and practical. They may range from the use of electronic media to face to face discussions;
- In preparation for consultation, all parties will be provided with adequate background information and time to review the information, such that the consultation is maximally effective;
- In addition to background information, the consulting parties will be provided with a clear statement of the nature of the advice sought;
- Organizations and individuals consulted will be given a specific and reasonable time to respond, and feedback will be provided to the consulting parties within a reasonable time frame; and
- Organizations consulted will be provided with a specific SAMHSA point of contact for response. The single point of contact for coordination of the formal process of consultation with tribal governments will be the Office of Policy and Program Coordination (OPPC), within the Office of the Administrator, which has responsibility for intergovernmental activities, including liaison with the HHS Office of Intergovernmental Affairs.

Mechanisms for Additional Consultation

- SAMHSA will continue to explore a number of avenues of outreach to tribal governments. They could include paper and visual media, electronic communications via Internet, teleconference, video conference, etc.
- SAMHSA will continue to collaborate with the HHS Office of Minority Health (OMH) and IHS in working with the OMH regional health coordinators and the IHS area offices to facilitate and coordinate consultation.
- As SAMHSA develops its linkages with tribal colleges and universities, these institutions may also serve to strengthen the communications/consultation links between SAMHSA and tribal governments.
- SAMHSA will also explore the possibility of participating in key AI/AN meetings, such as those of the National Indian Health Board and the National Congress of American Indians, as another means of fostering consultation and collaboration.

Areas for Further Exploration

Areas for further exploration with tribal government leaders and their staff include the following recommendations and issues:

- Tribal governments should be consulted early in the development of any program, project, conference or other activity directed to their communities.

- State block grant and program funding pose problems for tribal governments. There are some models of cooperation and mutual respect between tribal and State governments, and AI/AN prevention programs. These models should be identified and shared with the tribal governments as well as the States.

- To address the goals of local development and empowerment, the technical assistance requirements of tribal communities need to be addressed.

- Tribal communities need culturally competent services which require that service providers and outside evaluators be representative of the population served. When this is not possible, professionals involved in service delivery need to be aware and respectful of traditional methods of healing practiced by tribal communities, and be exposed to culturally competent curricula and cultural competency training.

- Service system changes, particularly Medicaid shifts to managed care, may pose additional access problems to tribal communities, especially in the areas of mental health and substance abuse services. These communities would benefit from greater technical assistance in the area of increased understanding of managed care.

Future Directions

- Program Development -- SAMHSA is currently undergoing a change in its programmatic focus. SAMHSA intends to expand and share the knowledge developed about the most effective methods of delivering substance abuse and mental health services to all communities. A key to effective services for tribal communities is culturally appropriate care and a recognition of the value of many traditional healing practices. Such healing practices have benefited these communities and should be respected as well as integrated into SAMHSA service models. SAMHSA will seek guidance from tribal communities to assist in developing programs that include this traditional health knowledge.

- Policy Development -- SAMHSA has sought and will continue to seek policy guidance from the AI/AN representatives and experts who serve on SAMHSA advisory councils and other panels.

- Budget Development -- SAMHSA will work with the HHS Office of Intergovernmental Affairs and the Assistant Secretary for Management and Budget, as well as the Indian Health Service, in the implementation of the findings and recommendations from the HHS budget consultation conferences.

- Legislation Development -- SAMHSA will work with the HHS Assistant Secretary for Legislation and IHS in providing legislative consultation to tribal governments.

SAMHSA Tribal Consultation Point of Contact

The coordination of issues involving tribal consultation is focused in the Office of Policy and Program Coordination within SAMHSA's Office of the Administrator. OPPC's focal point person for intergovernmental affairs, including tribal consultation, is:

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December 2000

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APPENDIX 5

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Fran Villegas
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Bill Old Chief
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APPENDIX 6

National Tribal Consultation Forum

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APPENDIX 7

Responses from Department of Health and Human Services Operating Divisions Regarding Issues and Recommendations Generated at the Tribal Government Listening Councils 2000

Index of Issues

SECTION:

V. INTERGOVERNMENTAL RELATIONSHIPS

1. Opportunities for Partnerships
2. Establish a DHHS Advisory Committee
3. Planning and Coordination in Tribal Consultation Process
4. State Outreach and Coordination
5. Direct Funding from Federal Government to Tribal Governments
6. Assess Impact of Welfare Reform on Indian Families
7. Budget Formulation Consultation
8. Raise the Ceiling on Indirect Costs Allowances for Head Start and Other Programs
9. Provide Technical Assistance for Tribes to Better Access DHHS Programs
10. International Border Issues when Serving Indian Families Residing Along Boarders
11. Create Consultation Process that is not a Burden for Tribes
12. Fill the Permanent Position for Tribal Liaison in Office of Intergovernmental Affairs
13. Elevate the Position of IHS Director to Assistant Secretary
14. Communication via National Organizations and Other Means
15. Rules for Tribes and TANF Funds Carry-Over
16. Tribes on International Borders Subsidizing Costs for Health Care for INS
17. Status of Current DHHS OPDIV Consultation Plans
18. State Reluctance to Coordinate
19. Indian Health Care Improvement Act

VI. INFRASTRUCTURE

1. Deterioration of Water and Sewer Systems

VII. DATA AND RESEARCH

1. Tribal Research
2. Establish a National Data Base
3. Community-Based Research

VIII. CONCERNS FOR OTHER DEPARTMENTS

SECTION I: FUNDING/BUDGET ISSUES

#1		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Lack of funding for health services and transportation to receive health services.	Establish line item budget for health services. Support appropriation for health services at level of need.	ACF, AOA, CDC, HRSA, HCFA, IHS, SAMHSA

1. Public Law(s) or authorization related to this issue/issue area:

IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

ACF RESPONSE: There is no ACF program authority that authorizes funding for health services with the somewhat narrow exception of Head Start (HS). Part 1304 -- (HS) Performance Standards, the regulations for HS program operations, require a health component designed to foster healthy development in low-income children. HS is considered the program of last resort in providing funding for health services as defined in the HS health component. All available resources must be used and collaborative efforts and partnerships attempted before HS funds are used for health services.

AOA RESPONSE: Older Americans Act (OAA) – Title VI (Timeline – long term/ongoing)

HCFA RESPONSE: Section 1905 of the Social Security Act identifies the mandatory and optional services states may cover under their Medicaid programs. Section 1902(a)(10) identifies the groups that are eligible to receive Medicaid.

CDC RESPONSE: Not Applicable to CDC as this Agency does not provide direct health care services.

HRSA RESPONSE: Sections 330, 330A of the Public Health Service Act, and Title V of the Social Security Act.

SAMHSA RESPONSE: (see issue area #'s 8, 15, and 22.)

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:

IHS RESPONSE: The Indian Health Service includes Tribal leadership in its annual budget formulation process. Tribal leaders identify target funding to meet health care needs of American Indians and Alaska Natives. In a comprehensive process, tribal leadership worked to reach consensus on key policy issues for reauthorization of the Indian Health Care Improvement Act P.L. 94-437. In follow-up to P.L. 94-437 reauthorization, a comprehensive analysis of Indian health programs as "entitlement" is planned. A study is underway to examine health-funding parity for Indian people compared to the Federal Employees Health Benefit Plan. This study, known as the Level of Need Funded (LNF) study, uses actuarial methods to estimate the costs of a mainstream benefits plan for Indians. Consultation with Indian tribes is still ongoing. The IHS is consulting with Indian tribes about the possibility of using LNF study results in new resource allocation formulas to address inequities within Indian country.

ACF RESPONSE: Not applicable.

AOA RESPONSE: Transportation is an optional supportive service under Title VI. Tribes have the option of providing transportation for elders to receive health services. Additionally, some Tribes use Title VI program volunteers to provide needed transportation for elders.

HCFA RESPONSE: Regulations at 42 CFR 431.53 assure transportation is provided to access covered Medicaid services.

3. OPDIV/STAFFDIV activities to date on this issue/issue area:

IHS RESPONSE: The agency currently has a budget activity called "services" which includes all health services with the exception of environmental health support services.

ACF RESPONSE: The HS health component objective is to ensure that, through collaboration among families, staff, and health professionals, all child health and developmental concerns are identified, and children and families are linked to an ongoing source of continuous, accessible care to meet their basic health needs. This includes medical, dental, mental health, and nutrition. HS health standards address the initial determination of a child's health status and developmental needs, and discuss ongoing services provided in collaboration with parents and professional service providers. HS vehicles can be used to transport HS children to medical/dental facilities for health services. Issue #1: Community partnerships and establishment of links with community organizations/programs are vital to HS programs. This ensures that children and families receive an array of individualized services, and that community resources are used in an efficient and effective manner.

AOA RESPONSE: The Administration on Aging (AoA) approves applications that include transportation to receive health services.

HCFA RESPONSE: HCFA recognizes that unless needy individuals can get to providers of medical services, the goals of the Medicaid program are seriously compromised. Thus, Medicaid's policy on coverage of transportation services is described under several authorities. Assurance of transportation to and from providers is a mandatory State plan requirement (42 CFR 431.53). The methodology used by the State to reimburse for transportation services determines the Federal financial participation rate. Transportation costs can be covered as an optional medical service or as an administrative expense. Transportation can be claimed as an optional medical service only when furnished by a provider to whom the State Medicaid agency makes a direct payment. The service must meet the requirements outlined in regulations at 42 CFR 440.170(a) and all other requirements related to Medicaid services. Transportation claimed as an administrative expense allows greater flexibility in the way services are provided.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: The services component of the IHS budget was $2.074B in FY2000 and the President proposed $2.271B for FY2001.

ACF RESPONSE: There is no prescribed amount of funds within a HS grant to address the health component or to cover transportation. HS grantees are expected to meet the health performance standards within their funding level.

AOA RESPONSE: No specific appropriation is designated for transportation.

HCFA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**

IHS RESPONSE: Despite the change from Federal deficits to Federal surpluses the budget caps established by the Balanced Budget Act of 1997 remain in affect through FY 2002. The FY 2001 budget allocation provided for the House Interior Appropriations Subcommittee was $302 million below the FY 2000 level and $1.7 billion less than the amount requested by the Administration. While the Senate Interior Subcommittee has received a budget allocation that is greater than the House's, it is still significantly below the President's request. The President has proposed discretionary spending limits at levels necessary to serve the American people, including American Indians/Alaska Natives. The Administration has consistently reminded Congress that the allocation to the Interior Subcommittees is insufficient to make the necessary investments in Indian programs.

ACF RESPONSE: Not Applicable

AOA RESPONSE: It is at the option of the Tribe to use Title VI funds for supportive health services, including transportation.

HCFA RESPONSE: Among the greater obstacles in addressing the provision of transportation for Native Americans are cultural sensitivity, distance, communications/language, and sovereignty issues. A unique situation that States face is how to deal with the sovereign nation status of many Tribes. This challenge does not exist with any other population. To build effective relationships, States must have a working knowledge of Federal and State laws and policies governing the relationships and provision of services. Often State resolution of these issues requires working with each tribe independently. Also, the importance of accurately identifying the decision-making Tribal official poses some difficulty for the States. There is currently no line item for tribal health services. HCFA does not submit an annual appropriations request for Medicare benefits. Medicare benefits are paid on the basis of what is called permanent, indefinite appropriation authority. Essentially this means that trust

fund monies can be used to pay for all authorized benefits. Medicaid is a Federal-State matching program that, under current law, makes grants only to States and territories. Although the Medicaid appropriation could be modified to include a tribal health services line item, statutory modifications would need to be made to Title XIX. For example, how would the tribes match the Federal share? Would the States reimburse for tribal members living in those States? Would individuals have the option of entitlement under the tribal plan or the State plan? Would the line items include all Medicaid-covered services available to tribe members, or only the additional services? Under Title XXI, statute currently authorizes a $30 million annual transfer to the Indian Health Service, for fiscal years 1998 through 2002, for special diabetes programs for Indians. Neither current appropriations language or authorizing language in Title XXI provides for any other explicit funding for tribal health services.

6. Strategies to overcome obstacles:

IHS RESPONSE: The Indian Health Service needs to continue to present the health care needs of Indian people in such a way that our budget is a top priority whenever funding allocation decisions are made. This will include consulting with tribal representatives, and working with staff from HHS, OMB and the Appropriations Committees, to ensure that the information needed to make the most compelling possible case is presented in a timely manner.

ACF RESPONSE: Not Applicable

AOA RESPONSE: AoA will encourage Title VI programs to increase coordination with IHS and Tribal health programs to facilitate meeting transportation needs of elders. The OAA allows for transportation services within the supportive service program and encourages the use of volunteers in providing services. Although transportation is primarily provided for taking elders to and from the senior centers, some programs provide (at their discretion) transportation for health services.

HCFA RESPONSE: HCFA has long realized the importance of transportation as a Medicaid service. In response to the many instances of misunderstandings of Medicaid policy governing this program area, HCFA established an interim Medicaid non-emergency transportation technical advisory group (TAG). The TAG worked for two years to identify transportation issues confronting the States, beneficiary groups and the provider industry. In June 1998, the TAG highlighted its findings and recommendations in a report to HCFA. The report, titled "Designing and Operating Cost-Effective Medicaid Non-Emergency Transportation Programs - A Guidebook for State Medicaid Agencies," is an insightful assessment of transportation issues as they impact the nation's various population segments. One of the chapters in the TAG's report addresses coordination of transportation services for Native Americans. In short, there is no one solution to the obstacles. Rather, the TAG recommends using multiple methods to resolve transportation issues. For example, some States are contracting directly with Tribal providers to provide services to their members. Utah also helped a rural hospital to become enrolled as a transportation provider. Other States, using the brokerage system, assure that Native American clients receive appointment confirmation prior to the provision of service, as all other clients. The TAG notes that States have found it beneficial to develop a relationship with Tribes and to identify key players in the State and Tribal leadership. For payment under Medicare, Congress would need to enact legislation stipulating that desired services would be covered under Medicare. For Medicaid and SCHIP legislative changes would be needed to make possible payment of services under a tribal health services line item.

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
IHS RESPONSE: W. Craig Vanderwagen, M.D., Director, Division of Clinical and Preventive Services. Indian Health Service, (301) 443-4644

ACF RESPONSE: Tom Tregear, Chief, American Indian Programs Branch, Head Start Bureau (202) 205-8437

AOA RESPONSE: Yvonne Jackson, Director, Office of American Indian, Alaskan Native and Native Hawaiian Programs (OAIANNHP), (202) 619-2713

HCFA RESPONSE: Mary Vollin, Health Insurance Specialist (202)690-6257, Bill Surine (HCFA/OFM) – (410)786-5407 (NOTE: Before any future activities can take place HCFA will need more specific information on the transportation issues in question in order to be more responsive.)

SAMHSA RESPONSE: Steve Sawmelle, Intergovernmental Coordinator , Office of Policy and Program Coordination, (301) 443-0419

SECTION I: FUNDING/BUDGET ISSUES

#2		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Lack of funding for water and sewer maintenance/repair, and testing of water on reservations	Appropriately fund maintenance and improvements.	IHS, CDC

1. Public Law(s) or authorization related to this issue/issue area:
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

CDC RESPONSE: CDC is not directly involved in water/sewer maintenance/repair, but its mission does include the monitoring and prevention of waterborne diseases — an activity that sometimes involves water testing. Testing of water on reservations, however, has not been a recent CDC activity. Public Health Service Act, particularly Title III, General Powers and Duties of the Public Health Service CDC derives its authority for the testing of water on reservations primarily from the Public Health Service Act (42 U.S.C. §§1, 242(l), 242(n), 242(o), 243, 249, 252, and 254) which allows the CDC to prevent the spread of disease, promote the quality of life, monitor chronic disease, and to prevent illness, injury, and disability. As part of the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), the CDC operates the Oral Health Program which may monitor the fluoridation of the water supply on such reservations;

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:
IHS RESPONSE: The IHS does not own, operate, or maintain water or sewer systems. However, P.L. 102-573 does authorize the IHS to provide a portion of the cost of operation and maintenance of sanitation facilities including individual facilities; the IHS has not requested funding for this authorization and Congress has never provided additional funding for this purpose. Routine water testing is the responsibility of the water system owner and must be done in accordance with EPA regulations.

CDC RESPONSE: Ready to assist in the event of waterborne disease outbreaks; CDC will collaborate with IHS in developing a demonstration project to assist small water systems in improving the quality and safety of water fluoridation, and to meet the recommendations of EARWF (*Engineering and Administrative Recommendations for Water Fluoridation,* 1995). This collaboration will ensure that technical assistance and training are provided to tribal programs located in the Albuquerque, Navajo, Phoenix, Tucson, and Oklahoma Areas; CDC is ready to assist tribal communities and IHS in the event of waterborne disease outbreaks;

3. OPDIV/STAFFDIV activities to date on this issue/issue area:
IHS RESPONSE: The IHS continues to assist tribes with unanticipated water and sewer emergencies where there is a risk to public health. (Also, since the program's earliest days the IHS has assisted tribes, in conjunction with its sanitation facilities construction projects to establish and equip operation and maintenance organizations.) Additionally, the IHS staff and contract trainers have provided extensive training and technical assistance to tribal/native utility operators and organizations.

CDC RESPONSE: Pilot project with Navajo Nation to assess water storage/hauling practices and test acceptability of new water storage containers; and Funded the Tohono O'Odham Tribe and the Prairie Island Indian Community to establish water fluoridation programs;

4. Appropriations information related to the issue/issue area (FY00, FY01):
IHS RESPONSE: For FY 2000 and FY 2001, the IHS continues to budget an amount up to $500,000 for funding projects to address unanticipated emergencies where there is a risk to public health. The IHS continues to support training of tribal operation and maintenance personnel with $900,000 each year. These funds are to pay for operation and maintenance training activities, including development of training programs.

CDC RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**

IHS RESPONSE: Despite the change from Federal deficits to Federal surpluses the budget caps established by the Balanced Budget Act of 1997 remain in affect through FY 2002. The FY 2001 budget allocation provided for the House Interior Appropriations Subcommittee was $302 million below the FY 2000 level and $1.7 billion less than the amount requested by the Administration. While the Senate Interior Subcommittee has received a budget allocation that is greater than the House's, it is still significantly below the President's request. The President has proposed discretionary spending limits at levels necessary to serve the American people, including American Indians/Alaska Natives. The Administration has consistently reminded Congress that the allocation to the Interior Subcommittees is insufficient to make the necessary investments in Indian programs.

CDC RESPONSE: Lack of community water systems/infrastructure in many AI/AN communities;

6. **Strategies to overcome obstacles:**

IHS RESPONSE: The Indian Health Service needs to continue to present the health care needs of Indian people in such a way that our budget is a top priority whenever funding allocation decisions are made. This will include consulting with tribal representatives, and working with staff from HHS, OMB and the Appropriations Committees, to ensure that the information needed to make the most compelling possible case is presented in a timely manner.

CDC RESPONSE: N/A to CDC efforts (other agencies responsible for water/sewer infrastructure)

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

IHS RESPONSE: E. Crispin Kinney, Acting Chief, Environmental Engineering Branch, Division of Facilities and Environmental Engineering, Office of Public Health, Indian Health Service, (301) 443-1046

CDC RESPONSE: Ralph T. Bryan, MD, Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, , Office of the Director, CDC, 505-248-4226
Dean S. Seneca, MPH, Minority Health AI/AN Program Specialist, Office of the Associate Director for Minority Health,, Office of the Director, CDC, 404-639-7210

SECTION I: FUNDING/BUDGET ISSUES

#3		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Lack of funding to build, expand, replace, and maintain health care facilities.(Tribal leaders expressed concern that construction funds to replace existing facilities do not address the need for planning for future facilities, services, or technological advances.)	Find innovative financing for tribes to build health care facilities.	IHS, HCFA, HRSA

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

HCFA RESPONSE: There are no provisions under Medicare or Medicaid for direct funding to build, expand or replace facilities. However, payment may be made for capital-related costs, such as depreciation, interest, betterment and improvements, certain leases, and insurance. Section 1886(g)(1) of the Social Security Act addresses reimbursement for capital-related costs for facilities being reimbursed under the prospective payment system (PPS). Section 1861(v) of the Act addresses the payment for facilities being reimbursed on a cost basis. Capital-related costs are identified at 42 CFR 431.130, Introduction to capital-related costs. Maintenance costs are reimbursable as operating costs and are included in the PPS payment or as a cost basis as appropriate.

HRSA RESPONSE: Title XVI of the PHS Act.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The IHS will continue to advocate for joint venture funding and small ambulatory grants, which are authorized under P.L. 94-437. Additionally, the IHS will continue to identify and inform tribes of options available for innovative tribal financing for health care facility construction.

HCFA RESPONSE: No further action is to be taken.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE:; The *Report of Roundtable Discussion and Analysis of Future Options for Indian Health Care Facility Funding*, which was sponsored by the IHS at the U.S. House of Representatives Office Building on August 17 and 18, 1999, is being provided to all interested tribes, as an aid in developing alternate and innovative tribal financing for health care facility construction. At many locations, IHS is addressing shortfalls in funds to expand and renovate health care buildings by using Medicare and Medicaid funds.

HCFA RESPONSE: Facilities are currently receiving capital related payments. However, no payment was made for PPS hospital for the period from 1992 through 1997, because of insufficient data.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE:; The IHS has requested construction funding for two hospitals and design/construction funding for two health centers in the FY 2001 President's Budget. Additionally, construction funds to continue the dental unit, new and replacement program; and IHS are also requesting approximately $2.5 million for small ambulatory grants. The IHS anticipates first time funding for this grant program in FY 2001. The ambulatory grants program will assist smaller tribes who will construct their own health care facilities and will provide them with better access to health care services.

HCFA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area: lack of Congressional appropriations and staff to assist tribes.**

IHS RESPONSE:; Identified in the ... *Roundtable Report* cited in question 3 above, the obstacles are limited experience in seeking alternative funding or financing and a lack of technical assistance; securing adequate staffing for new facilities; and a perception that tribes may be relieving the Federal government of its trust responsibilities by pursuing alternative funding.

HCFA RESPONSE: N/A

6. **Strategies to overcome obstacles:**

IHS RESPONSE:; New budget directives via a budget reconciliation bill would have to be taken up the Senate Budget Committee and other Senate leaders to allow the levels of spending to be increased.

HCFA RESPONSE: N/A

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE:; Jose F. Cuzme, P.E. Chief, Facilities Engineering Branch, Division of Facilities and Environmental Engineering, Office of Public Health, Indian Health Service, 301-443-1850

HCFA RESPONSE:; Ann Pash (HCFA) – (410) 786-4516

SECTION I: FUNDING/BUDGET ISSUES

# 4		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Lack of funding for Traditional Native Healers/Practices		IHS, ACF, HCFA, HRSA, SAMHSA

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE:; The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis. It is the policy of the Indian Health Service to encourage a climate of respect and acceptance in which an individual's private traditional beliefs become a part of the healing and harmonizing force within his/her life. There were at least 10 regional Round Table discussions in Indian Country, but there was not consensus from these meeting that there should be Federal involvement in Traditional Healing at this time. It has been the IHS Director's position that this issue is a local matter and should best be addressed at a local level. He has and continues to advocate for Traditional Healing.

ACF RESPONSE: ; Native American Programs Act (NAPA) of 1974, as amended (ANA) does not authorize funds for health services. It does authorize a wide range of social development, economic development and governance development grants, all of which are culturally appropriate. The NAPA also includes authority to fund environmental regulatory enhancement grants and native language preservation grants.

HCFA RESPONSE: There is no specific authority to cover traditional native healers under Medicaid. However, it may be possible to cover these services under Section 1905(a)(13) of the Social Security Act. This section permits Medicaid payments for part or all of the costs for rehabilitative services, including any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an eligible Medicaid beneficiary to the best possible functional level.

HRSA RESPONSE: Title 330 of the PHS Act. Title V of the Social Security Act (Sec. 501(a), Section 1910 of the Public Health Service Act (EMSC) Such funding could be provided at a maternal and child health (MCH) site only under a Special Project grant, not under the State's Block Grant (see issue #5.) The Title III and Title IV programs of the Ryan White CARE Act provide primary health care services to individuals with HIV/AIDS and address the specific HIV and AIDS related health and support services needs of children, adolescents, women and families, respectively. Public Law 104-146, the Ryan White CARE Act of 1990, as amended by the Ryan White CARE Act Amendments of 1996. The Title I and Title II programs of the Ryan White CARE Act (excluding the AIDS Drug Assistance Program – ADAP) provide funding to disproportionately affected metropolitan areas and to all states, respectively, to provide health care and support services to individuals with HIV/AIDS. The funds are allotted to these areas and states, which then subcontract with medical and other support service providers. Under the current Ryan White CARE Act, it is possible for these providers to be tribal medicine and tribal healers.

SAMHSA RESPONSE:; 42 USC 290aa, 42 USC 290ff, 42 USC 300x

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: Dr. Trujillo has developed as one of his Initiatives, an emphasis on Traditional Healing and even though it has been unfunded the past three years, we continue to advocate for funding.

ACF RESPONSE: ANA will continue to increase current role of traditional Elders in the Elder's Circle, as described below. ANA will also continue to emphasize the role of elders in tribal language projects using elder speakers.

HCFA RESPONSE: ; In consultation with IHS and OGC, HCFA will continue to examine this issue to determine the extent of flexibility allowable under the statute and regulations for coverage of these services, outside of their possible inclusion as rehabilitation services. If such services can be covered, HCFA will inform both the States and Tribes. States would then have the option to extend coverage of these providers under an approved Medicaid State plan.

HRSA RESPONSE: N/A and Regarding HIV/AIDS, "none"

SAMHSA RESPONSE: Subject to availability of funds, CMHS' Circles of Care program will be reissued to tribal communities. The Child Mental Health Initiative is scheduled to continue at the present funding level through FY 2001. There is now a significant volume of research that indicates there is less substance use and abuse among adolescents who participate in spiritual or religious practices. Because this role of religion generalizes to multiple demographic subgroups, including AI/ANs, CSAP will continue to emphasize the importance of spirituality and the participation of traditional healers in substance abuse prevention programs. Although at this time there are no traditional healing services funded at Tribal Colleges and Universities (TCUs) by SAMHSA's Office of Minority Health (OMH), the Office will continue to ensure that TCUs receive mailings of all grant/contract opportunities to fund traditional healer services at TCUs.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The topic has been presented at many national meetings.

ACF RESPONSE: : Commissioner of ANA established a traditional Elder's Circle to provide input and recommendations to Commissioner regarding ANA funding priorities and issues of concern among Tribes and in other Native communities. Each elder who is a member of the Elder's Circle is a Traditional healer. ANA has consistently emphasized the importance of including elder speakers in Native language projects due to fact that many Tribes are loosing their speakers and also to address including elders in the language budget. Three to four years ago ANA was interested in exploring the area of Traditional Healers and how to access this expertise and knowledge in an effort to improve health care among Indian Tribes. ANA identified a group of Traditional Healers and formed a traditional Elder's Circle. This group of tribal elders has been actively engaged in discussions concerning Traditional Healers/practices. Among the activities which have taken place are: (1) identification of Traditional Healers among federally-recognized Tribes; (2) discussions were held with IHS regarding access to health care providing agencies; and, (3) identification of examples of coordination between Traditional Healers and former medical care providing agencies. In addition the Elders Circle has been involved to provide input and recommendations to the ANA Commissioner regarding ANA funding priorities and issues of concern among Tribes and other Native communities, such as sacred sites, cultural preservation, language preservation, parenting and other issues affecting children and families. Based on recommendations from the field ANA continues to emphasize the importance of including elder speakers in Native language projects due to fact that many Tribes are losing their speakers. ANA has contributed funds through an interagency agreement with the Bureau of Indian Affairs for a project that involves using Traditional healing. This project is the Indian Family Restoration Project on the Sisseton Wahpeton reservation which works with entire families whose youth who are practicing unhealthy life styles. The project emphasizes the importance of culturally relevant role models as demonstrating positive coping life skills which are critical to the effort to combat drug abuse, violence, juvenile delinquency, suicide, and the continuing disintegration of the family unit. Traditional healing practices are key to this project.

HCFA RESPONSE: In the early 1990's HCFA issued guidance to the States that it may be possible to cover such healers/practices under the rehabilitation service rubric, if it is determined that the services meet the definition of "rehabilitation services", since regulations (42 CFR 440.130) do not necessarily preclude coverage of traditional healers.

HRSA RESPONSE: N/A and regarding HIV/AIDS, "none"

SAMHSA RESPONSE:; A 3-year discretionary grant program of SAMHSA's Center for Mental Health Services (CMHS), the Circles of Care, is targeted to tribal communities for the improvement of the system of care for children and youth with

serious emotional disturbances. One of the program's objectives is to integrate traditional healing methods indigenous to the communities with conventional treatment methodologies. The initial grant program of FY 1998 includes 9 tribal and urban Indian communities. A specific issue is compensation of traditional healers. Some communities are exploring certification of the services, for billing purposes. In another CMHS grant program, the Child Mental Health Initiative, begun in 1993, tribes are eligible along with states, to apply for 5-year grants for the implementation of a comprehensive service system of care for children with serious emotional disturbances. Eight tribes have participated to date, and have each been including traditional healing in ways specific to the community, and specific to family choice. Since 1989, traditional healers, elders, and medicine men/women have participated extensively in the American Indian/Alaska Native (AI/AN) prevention programs of SAMHSA's Center for Substance Abuse Prevention (CSAP) for high risk youth. Discretionary funds of SAMHSA's Center for Substance Abuse Treatment (CSAT) , as well as funds from the Substance Abuse Prevention and Treatment (SAPT) Block Grant, may be used for innovative practices serving Indian populations, including the use of traditional healing practices, at the option of the provider/grantee.

4. **Appropriations information related to the issue, issue area (FY00, FY01):**
IHS RESPONSE: Requests were not funded

ACF RESPONSE: Not Applicable.

HCFA RESPONSE: N/A

HRSA RESPONSE:

	FY 00	FY 01
Special Projects of Regional and National Significance (SPRANS) set aside:	$109.4 mil	$109.1 mil.
Community Integrated Service Systems	$12 mil.	$ 12 mil. (CISS) set aside* Grants to
states	$582.7 mil.	$582.7 mil.

*Projects funded in FY 00 to benefit American Indians:

Countywide Integration of a Social Services System	Beltrami County Public Health Nursing Service	Bemidji, MN	$50,000
Blackfeet PRIDE (Prenatal& Infant Development Education) Project	Blackfeet Tribe	Browning, MT	$49,607
Head Start Program			
Honoring Our Children	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI	$50,000

Regarding HIV/AIDS: See following summary of HRSA-funded activities that target American Indian and Alaska Native populations:

Project Title: Alaska Native Health Board Planning Grant
The Alaska Native Health Board (ANHB) Planning Grant is funded through Title III of the Ryan White CARE Act. During the course of the year planning the ANHB will conduct planning activities such as identifying key HIV/AIDS stakeholders in the service area; completing and prioritizing a comprehensive medical needs assessment of people living with HIV; completing a comprehensive assessment of interest, knowledge, experience and capacity of medical providers; and strengthening clinical, managerial and MIS infrastructures. These planning activities will prepare the ANHB to develop an application for a Title III funded Early Intervention Services program to provide counseling, outreach and treatment for Alaska Natives with HIV/AIDS.
Project Contact: Andrew Kruzich, Division of Community Based Programs, HIV/AIDS Bureau (301) 443-0759

Project Title: Inter-Tribal Health Care Center Planning Grant
The Inter-Tribal Health Care Center (ITHCC) of Tucson, Arizona Planning Grant is funded through Title III of the Ryan White CARE Act. The ITHCC targets health care, health promotion, and disease prevention specifically for urban American Indians. During the course of the one year planning grant, the ITHCC will serve as a liaison between urban American Indians and community HIV/AIDS health care providers. In serving as a liaison, the THCC will 1) identify and establish an HIV prevention education program which coincides with American Indian

culture and values; 2) implement HIV testing and strengthen counseling on HIV/AIDS at the ITHCC facility; 3) institute referral and sub-contracting services for urban American Indian HIV positive patients with HIV/AIDS health care providers in Tucson; and 4) initiate staff training on American Indian culture at sub contracted facilities. Due to its established role in health promotion and disease prevention, ITHCC is ideal for planning and initiating HIV/AIDS services and education targeting American Indians residing in Tucson. These planning activities will prepare the ITHCC to develop an application for a Title III funded Early Intervention Services program to provide counseling, outreach and treatment for American Indians in the Tucson area with HIV/AIDS.

Project Contact: Andrew Kruzich, Division of
Community Based Programs, HIV/AIDS Bureau, (301) 443-0759

Project Title: **Alaska Target Provider Education Demonstration (TPED) Project**

Alaska Targeted Provider Education Demonstration Project will provide state-of-the-art HIV/AIDS education, training, consultation and support to non-clinician providers working with HIV-infected Alaska Native/Alaska Indian populations in Alaska. Training activities include information exchange/dissemination via electronic newsletter and fact sheets, website posting methods, and conventional mail, including production and distribution of a video on HIV/AIDS treatment; in-person training conducted in locations selected to provide coverage of the entire State; a video produced on adherence issues and used for facilitated video teleconferences to provide interactive learning; telephone and electronic consultation services to non-clinician providers. The project's anticipated impact is a network of trained non-clinician providers knowledgeable about HIV/AIDS care management in general, skilled in providing care to HIV-infected AN/AI persons, and skilled in supporting them to overcome the cultural and other barriers affecting adherence and access to care. **Project Contact:** Rene Sterling, Division of Training and Technical Assistance, HIV/AIDS Bureau, (301) 443-777

Project Title: **Alaska Native HIV/AIDS Case Management Project**

The Alaska Native HIV/AIDS Case Management Project is a consortium effort involving three regional Alaska Native health corporations - Chugachmiut, Yukon Kuskokwim Health Corporation and Kodiak Area Native Association - serving a combined Native population of 26,617. The project is developing and implementing regional case management systems which coordinate and integrate services for people living with HIV/AIDS in rural and remote Alaska Native villages in a manner which supports their stay in the village or as close to home as possible. In addition, the project is developing resources and offering services which reduce transmission of the HIV virus among village residents. **Project Contact:** Barbara Aranda-Naranjo, Director, Special Projects of National Significance, Office of Science and Epidemiology, HIV/AIDS Bureau,(301) 443-4149

Project Title: **Native Care: HIV/AIDS Integrated Service Network**

In response to the increasing spread of HIV among American Indian, Alaska Native and Native Hawaiian populations, eight regional case management sites around the country have joined with the National Native American AIDS Prevention Center (NNAAPC) to create an innovative venture to meet with needs of Native Americans with HIV/AIDS. The Native Care: HIV/AIDS Integrated Service Network employs a model of coordinated client access to provider agencies, including medical, mental health, nursing care, social, essentials of life, substance abuse, and traditional healing services. The program offers a comprehensive, integrated service-delivery program that is built on free-standing, culturally responsive, and adaptable case management model. Sites also link to a national Network office that provides a variety of services including administrative oversight, training, technical assistance, information exchange and dissemination, and program design and evaluation. **Project Contact** Barbara Aranda Naranjo, Director, Special Projects of National Significance. Office of Science and Epidemiology.
HIV/AIDS Bureau (301) 443-4149

Project Title: **Navajo Integrated HIV Service Delivery Model Program**

The Navajo Integrated HIV Service Delivery Model Program will conduct a once year comprehensive, HIV planning initiative that will define and evaluate the integration of HIV services into existing services currently provided by the Indian Health Service (IHS), the Bureau of Indian Affairs(BIA), Navajo Nation community-based providers, and Native traditional practitioners. In subsequent years, the program will integrate services through a competitive bid process open to Navajo Nation community-based providers. The model for integration of

services is multi-dimensional, multi-sectoral and integrates existing scientific and professional disciplines with community based service providers and traditional practitioners. **Project Contact:** Barbara Aranda-Naranjo, Director, Special Projects of National Significance, Office of Science and Epidemiology. HIV/AIDS Bureau(301) 443-4149

Project Title: AIDS Education and Training Center Programs
The Indian Health Service (IHS) through funds from the Secretary's Communities of Color HIV/AIDS, Emergency Fund, is targeting funds for HIV/AIDS training to Indian Health Service providers, tribal health care providers and Indian urban health care providers. These funds are on a one-time basis from fiscal year (FY) 2000 funding. The goal of this initiative is to increase the knowledge and skill level of physicians, physician assistants, nurse practitioners, dental professionals, pharmacists, social workers, case `managers, certified health workers, etc. who are and/or serve the AI/AN population. The Health Resources and Services Administration (HRSA), in collaboration with HIS, will offer the American Indian/Alaska Native (AI/AN) providers this training initiative via a one-time supplement to the AIDS Education and Training Centers Program (AETC). In an effort to reach the most AI/AN providers and providers who care for this population, the IHS selected five AETCs which will receive the supplement funds and the five Native American Partner organizations. The purpose of the AETC is to improve the care of people living with HIV/AIDS by supporting clinical consultation, education, and training for health clinicians serving this population. This is accomplished through the training of health personnel, including practitioners in programs funded under the Ryan White CARE Act and other community providers, in the diagnosis, treatment and prevention of HIV disease, and including measures for the prevention and treatment of opportunistic infections. A particular emphasis is placed on reaching providers who care for individuals who lack adequate health care and/or who are at risk for HIV disease. These include health care professionals supported by other components of the Ryan White CARE Act, providers serving minority and disproportionately affected populations. **Project Contact:** Juanita Koziol, MS, NP, CS., RN, Division of Training and Technical Assistance, 301-443-6068, HIV/AIDS Bureau

SAMHSA RESPONSE: Circles of Care - FY 2000 - $2.4 million for grants; $8,000 for technical assistance. Child Mental Health Initiative - FY 2000 - $56.6 million for grants; $2 million for technical assistance. For 2001, basically level funding is proposed for both programs, subject to availability of funds.

5. Obstacles to addressing issue/issue area:
IHS RESPONSE: There are many American Indians/Alaska Natives (AI/AN) who do not want the presence of the Federal Government in this arena. There are also many AI/AN who consider themselves Christian and do not want to be involved in Traditional Healing. Many have objected to being asked in the clinical setting if they had sought the help of a Traditional Healer or would they like to have the services made available for them.

ACF RESPONSE: ANA grant projects are generated and designed at the local level; tribes and communities create their own projects. Applications submitted for ANA undergo a competitive review process and therefore there is no guarantee that applications will be funded. Concerning ANA funding to address Traditional Healers, ANA grant projects are generated and designed at the local level; tribes and communities create their own projects. Applications submitted to ANA undergo a competitive review process and therefore ANA funding is based on the outcome of this review process.

HCFA RESPONSE: If the review of the issue indicates that current policy precludes this flexibility, then legislation will have to be pursued.

HRSA RESPONSE: Lack of inclusion as priority in agency strategic plan. Underfunding for special projects Regarding HIV/AIDS: Statute requirement that primary care services be provided under direct supervision of physician.

SAMHSA RESPONSE: State funding entities under the SAPT Block Grant may not accept traditional healing practices as state-of-the-art and do not authorize certification and licensure of such practices. Frequently Initial Review Groups (IRGs) for grant funding do not understand the importance of using traditional healers, and traditional healers are not recognized by the medical establishment.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: Because the obstacles are on both sides, it appears there will need to be more work in gaining true consensus on this issue. Many of the Elders do not want Federal involvement in any way. Especially they have been adamant about the payment of these services from an outside source. The payment of the healing process is often part of the healing process!

ACF RESPONSE: ANA will continue to emphasize the importance of traditional Elders and healers by continuing current activities relating to Elders/healers. (ANA has a GPRA measure relating to Elders)

HCFA RESPONSE: See response to question #2 above.

HRSA RESPONSE: Interagency funding and collaboration for initial demonstration projects. Regarding HIV/AIDS: Statute requirement that primary care services be provided under direct supervision of physician.

SAMHSA RESPONSE: provide information and technical assistance to states and to SAMHSA's review and technical advisory committees to ensure the acceptability of such practices by providers of services to AI/AN populations.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: Kermit C. Smith, D.O., M.P.H., Chief Medical Officer, Office of the Director, Indian Health Service, 301-443-1083

ACF RESPONSE: Sheila Cooper, Native American Program Specialist, (202) 690-5787, Dr. Kenneth Ryan Native American Program Specialist (202) 410-7365

HCFA RESPONSE: Joyce Jackson, (HCFA) Technical Director (410-786-3257), Dr. Kenneth Ryan, Native American Program Specialist (202) 410-7365
NOTE: If it is determined that current statue allows the flexibility for coverage of these services, this issue can be handled in the short term. However, if the flexibility does not exist, this will be a longer term issue as legislation will be required.

HRSA RESPONSE: Karen Garthright, Public Health Analyst, Office of Minority Health, 301-443-9424
John Palenicek, PhD, Director, Office of Policy and Program Development, HIV/AIDS Bureau, (301) 443-4274

SAMHSA RESPONSE: Steve Sawmelle, Intergovernmental Coordinator , Office of Policy and Program Coordination, (301) 443-0419

SECTION I: FUNDING/BUDGET ISSUES

#5		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Lack of funding for prevention activities; funding only enough to address primary care.		IHS, SAMHSA, HCFA, CDC, HRSA

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

HCFA RESPONSE: Section 1905(a)(13) of the Social Security Act provides Medicaid payments to States in whole or in part for diagnostic, screening, and preventive services for the maximum reduction of physical or mental disability of an eligible Medicaid beneficiary. Preventive services are an optional benefit that States may choose to provide under their Medicaid programs.

CDC RESPONSE: This issue/issue area is CDC's highest priority and the majority of CDC efforts involving AI/AN populations fall within this area. As the Nation's Prevention Agency, CDC plays a pivotal role in working with tribal governments, Alaska Native corporations, and IHS to promote and facilitate prevention efforts in AI/AN communities through grants/cooperative agreements awarded to tribes and tribal organizations, partnerships and intra-agency agreements with IHS, training, tribal consultation, technical assistance, and direct assistance. Public Health Service Act, particularly Title III, General Powers and Duties of the Public Health Service; 25 USC 18, Subchapter II, Section 1621m.

HRSA RESPONSE: FOR MCH: Eligibility for funding under the Federal-State Grant authority of the Maternal and Child Health Block Grant is limited to 59 states and specified territorial jurisdictions. Indian tribes are not eligible. Except for research and training grants – for which eligibility is limited to institutions of higher learning – eligibility for project funding under the two Federal Special Projects authorities of the MCH Block Grant (Special Projects of Regional and National Significance [SPRANS] and Community Integrated Service Systems [CISS]) is open to all public and private entities including Indian tribes. *Research and training grants to benefit American Indians in FY 00 are listed at the end of this section.
Public Law 104-146, the Ryan White CARE Act of 1990, as amended by the Ryan White CARE Act Amendments of 1996.

SAMHSA RESPONSE: SAMHSA responds to this issue area at issue area #8, which is more specific to our mission.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: IHS has identified appropriate and cost effective prevention interventions in conjunction with the Tribes. Activities targeting prevention of chronic diseases and behavioral health illness have been identified as most critical prevention needs. Program interventions to address these needs have been identified. Many of these interventions are part of the increases proposed for clinical programs. Other Federal entities with resources in this area have been identified and IHS proposes to target these agencies for information sharing and advocacy.

HCFA RESPONSE: For the most part, States have sole discretion as to whether they will offer prevention services under their Medicaid programs. (States are required to cover basic EPSDT services and vaccines.) HCFA should continue to assure that all basic EPSDT and vaccine services are provided. Our latest data indicate that 32 States provide some form of preventive services to all or a portion of their Medicaid populations. However, the Center for Medicaid and State Operations within HCFA will be working with States and Tribes to increase Tribes' access to managed care contracts. One of the primary tenets of managed care is that the prevention of disease is less expensive and more efficacious than the curing of disease. By helping Tribes to participate more fully in managed care, they will have access to managed care methodologies, which may increase their access to prevention activities.

CDC RESPONSE: FY 2002: New AI/AN budget initiative under development to broadly support public health infrastructure and prevention activities within AI/AN communities; Continuation or expansion of most of the projects listed in #3 below; In FY 2000, develop two additional modules for grades 7 and 8 for an AI/AN-specific curriculum called *The Circle of Life* designed to provide young people with skills and information to avoid behaviors which put them at risk for HIV infection Pilot an AI/AN-specific version of *Be Proud! Be Responsible!*, a high school curriculum designed to prevent HIV infection;

HRSA RESPONSE: Increase outreach to tribal governments regarding their eligibility for these grants, send them the grant information, and provide technical assistance to those who wish to apply.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The agency has consistently proposed increases for prevention consistent with the tribal priorities established in the budget formulation process. Of note is that current services funding for inflation, pay costs, and population growth have been the highest priority items identified in the budget formulation process. These increases were deemed most necessary to maintaining the existing medical service programs during the consultation process. These funds also support clinical preventive activities in diabetes and other chronic diseases that are part of the primary care services. These priorities have resulted in the agency seeking funding increases for prevention in specific categorical budget activities rather than funding fee-standing generic health promotion and disease prevention programs, such as health education.

HCFA RESPONSE: N/A

CDC RESPONSE:

- National Breast and Cervical Cancer Early Detection Program - multiple tribal programs funded (including Navajo Nation, Cherokee Nation, Cheyenne River Sioux Tribe, Hopi, Southeast Alaska Region Health Consortium as well as other tribes and organizations);
- Funds were provided to the Southcentral Foundation (Cook Inlet, Alaska) to establish a Well Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program to provide additional preventive services, including lifesyle interventions, to participants in the breast and cervical cancer early detection program;
- Funds provided within the Preventive Health and Health Services Block Grant to the Santee Sioux and Kickapoo tribes for chronic disease prevention activities;
- HIV/STD Prevention:
  - Through a memorandum of agreement with the Bureau of Indian Affairs, NCCDPHP supported training for BIA elementary school teachers to deliver an AI/AN-specific curriculum called *The Circle of Life* designed to provide young people with skills and information to avoid behaviors which put them at risk for HIV infection. The curriculum was developed in collaboration with the BIA, IHS and CDC/NCCDPHP;
  - Four separate competitive programs that will provide support through directly funded Community Based Organizations (CBOs); Community Development grants; technical assistance for CBOs; and Faith-Based Initiatives; four tribal organizations currently funded;
  - In 1998 and 1999, NCCDPHP funded the first and second annual *Common Ground* conferences to increase HIV prevention activity by forming collaborations between State Departments of Education and AI/AN communities;
  - CDC's Syphilis Elimination Project
  - Technical assistance was provided regarding HIV prevention program planning and curriculum development and interpretation of Youth Risk Behavior Surveys conducted for the Navajo and the Bureau of Indian Affairs;
- The REACH 2010 Demonstration Project (Phase I) funded the Eastern Band of Cherokee Indians, the Minnesota Department of Health, Community Health Centers, Inc (Salt Lake City, Utah), and the Oklahoma State Department of Health. Each project is engaged in a community planning effort to develop a Community Action Plan to reduce health disparities in cardiovascular disease, diabetes, infant mortality, and immunizations among Native Americans;
- Pregnancy Risk Assessment Monitoring System (PRAMS) - includes AI/AN-targeted efforts in NM, OK, and AK;
- Provided funding to establish the National Diabetes Prevention Center in Gallup, New Mexico. The Center, in collaboration with IHS, the University of New Mexico, the Navajo Nation, the Pueblo of Zuni, Dine College, Zuni-Ramah PHS, and the Gallup Indian Medical Center, will address the epidemic of diabetes among American Indians;
- CDC provided funding to support activities of the American Indian Workgroup and for the development and production of the National Diabetes Education Program (NDEP) public service announcements specifically for American Indian audiences;
- AI/AN-focused Prevention Research Centers - New Mexico, Oklahoma
- Consultants to Healthy Start Program - Michigan InterTribal Council;
- Fetal Alcohol Syndrome (FAS) Prevention - WA Dept. of Health, AI populations targeted;
- Funded the Tohono O'Odham Tribe and the Prairie Island Indian Community to establish water fluoridation programs
- CDC Arctic Investigations Program (AIP) -(multiple projects throughout Alaska):
  - The Arctic Investigations Program conducts surveillance, epidemiologic and laboratory research, prevention projects, training, and information dissemination concerning infectious diseases/conditions that impact Arctic residents; particularly Alaska natives;
- Reduction of Exposure to Rodents in the Home -- Ramah Navajo Chapter;
- Community-Based Infectious Disease Programs -- Chugachmiut Alaska and Navajo Nation;
- Multiple vaccination evaluation projects targeting *H. influenza*, hepatitis A and B, and pneumococcal disease;
- Reducing the Risk of Mosquito and Tick-borne Infectious Diseases -- AI community partner: Eastern Band of Cherokee;
- Injury and Violence Prevention:
  - Child safety seat and safety belt usage programs for the prevention of motor vehicle injuries among Native Americans in New Mexico;
  - Smoke alarm distribution programs to prevent fire-related injuries among high risk communities including residences on Indian reservations;

- Collaborating with IHS to develop an *Atlas of Injuries Among Native American Children*, which will focus on eight leading causes of injury death for Native American children;
- Support development and implementation of the AI/AN Community Suicide Prevention Center and Network (CSPCN) for AI/AN communities;
- Albuquerque Area Indian Health Board intimate partner violence prevention project (a cooperative agreement) for urban Indians that includes: 1) developing a violence prevention task force; 2) a media campaign for IPV prevention; 3) a school-based prevention program; and 4) community gatherings (training) to build skills, promote prevention, and develop long-term prevention plans;
- Multiple prevention-oriented projects/programs ongoing in partnership with IHS and tribal communities/governments targeting priority health problems such as diabetes, cardiovascular disease, tobacco use, dental disease, sexually transmitted diseases, hepatitis, hantavirus, and injuries;

HRSA RESPONSE: See response to Issue #4

4. Appropriations information related to the issue/issue area (FY00, FY01):
IHS RESPONSE: The agency was appropriated $ 91.9M for preventive services in FY2000 and requested $103.4M in FY2001. The prevention budget activity does not however account for all prevention activities, many of which are supported under the Hospitals and Clinics, Mental Health, Alcohol, and Dental budget activities as well.

HCFA RESPONSE: N/A

CDC RESPONSE: HIV/STD Prevention activities: (FY 00) $1, 441, 948
Other infectious disease prevention/control activities: (FY 99) $2,897,395
In the FY 2001 President's Budget, CDC is requesting a $1.5 million increase to support REACH (Racial and Ethnic Approaches to Community Health) demonstration projects within AI/AN communities; FY 99 and 00 Senate Appropriations language urges the CDC to continue to develop a targeted diabetes prevention and treatment program for Native populations and provides funding to the National Diabetes Prevention Center (NDPC) in Gallup, New Mexico. Initial funding was provided to the NDPC in FY 98 Senate Appropriations language. However, no other specific Appropriations language requires NCCDPHP's chronic disease programs to "set-aside" funds or make tribes eligible for direct funding;

5. Obstacles to addressing issue/issue area:
IHS RESPONSE: The continuing lack of adequate funding for clinical services has contributed to shortfalls in primary and secondary prevention activities including those funded under clinical services and those prevention activities identified under the prevention budget sub-activity. Other HHS elements with prevention funding have not focused on the needs of Indian communities.

HCFA RESPONSE: N/A

CDC RESPONSE: Inadequate funding is an ongoing obstacle; Limited availability of AI/AN public health professionals hinders many community-based prevention efforts; Lack of awareness by many staff of the need to improve tribal eligibility for many prevention-oriented grants/cooperative agreements; Lack of trust from AI_ AN communities of federal agencies; Inadequate reporting of disease and/or injuries;

HRSA RESPONSE: See response to Issue #4. Also, Statutory requirements limiting the funding of prevention activities using Ryan White CARE Act dollars.

6. Strategies to overcome obstacles:
IHS RESPONSE: The agency and tribes must re-evaluate the commitment to clinical service programs and develop ways to highlight the preventive nature of many of these clinical efforts. The identification of preventive services within the prevention budget sub-activity falsely implies that this is the agency's total commitment to prevention activities and is misleading. In addition, continued dialogue and tribal consultation with all elements of HHS (e.g., CDC, SAMHSA, etc.) that may have prevention resources must be a priority. The Tribes and the agency have shown improvements in implementing such a strategy with recent Tribal organization participation in budget planning session and research planning sessions with CDC and NIH.

HCFA RESPONSE: HCFA's Center for Medicaid and State Operations is preparing a letter to State Medicaid Directors and Tribal Leaders urging them to work together on including IHS, Tribal and Urban providers in managed care delivery systems.

CDC RESPONSE: Develop new budget initiatives and engage tribal partners in the budget planning and priority process; Pursue new avenues and approaches to better recruitment of existing and training of future AI/AN public health professionals; Educate CDC staff regarding the Agency's unique relationship with, and special responsibilities to, AI/AN communities; Increase community needs assessment field studies; increase technical assistance services in preparation for grant applications; Ensure that tribes and tribal/urban Indian organizations are aware of opportunities to acquire injury prevention funding to establish basic programmatic core capacity to conduct effective community-based injury prevention programs; CDC will continue to examine its categorical programs to determine if there is any prohibitive language making tribes ineligible to apply for direct funding; CDC will explore funding opportunities in future years to support a number of important disease prevention initiatives that specifically target tribes; CDC will facilitate communication between C/I/Os to share advice about effective ways to work with tribes and identify effective funding mechanisms to fund tribes to prevent disease and injury;

HRSA RESPONSE: See response to issue #2. HRSA is currently finalizing a policy clarifying the circumstances under which Ryan White CARE Act funds may be used to provide services to American Indians and Alaska Natives through the Indian Health Service, tribally run facilities and urban Indian program. This policy is expected to be disseminated by late Summer, 2000.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: W. Craig Vanderwagen, M.D. Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service , (301) 443-4644

HCFA RESPONSE:
Nancy Goetschius (HCFA) -- (410) 786-0707

CDC RESPONSE: Ralph T. Bryan, MD, Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, Office of the Director, CDC, 505-248-4226
Dean S. Seneca, MPH, Minority Health AI/AN Program Specialist, Office of the Associate Director for Minority Health, Office of the Director, CDC, 404-639-7210

HRSA RESPONSE: Karen Garthright, Public Health Analyst, Office of Minority Health, 301-443-9424. John Palenicek, PhD, Director, Office of Policy and Program Development, HIV/AIDS Bureau, (301) 443-4274

SECTION I: FUNDING/BUDGET ISSUES

#6		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Underfunding of Community Health Representative and Clinical Health Nurse Programs		IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: IHS has worked with the tribes to identify the priority needs in this area. The agency has sought means to enhance these activities and proposes to continue advocacy for these needs through targeted resource development. The agency proposes to work with HCFA to identify barriers to reimburse for community-based activities.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The agency has continued to advocate for program increases in both public health nursing and CHR activities consistent with the consultative budget formulation process. The community-based health services, including outreach and home health care routinely results in preventing or shortening hospital stays and often function in lieu of visits to outpatient clinics. The agency is focusing on the use of the public health nursing/CHR team in meeting the needs of two vulnerable populations: mothers and infants, and elders. The IHS is working with HCFA to develop reimbursement strategies for these activities.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: The FY 2000 appropriation for these two activities was approximately $80.8M and the President proposed approximately $90.8M in FY2001.

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: Despite the change from Federal deficits to Federal surpluses the budget caps established by the Balanced Budget Act of 1997 remain in affect through FY 2002. The FY 2001 budget allocation provided for the House Interior Appropriations Subcommittee was $302 million below the FY 2000 level and $1.7 billion less than the amount requested by the Administration. While the Senate Interior Subcommittee has received a budget allocation that is greater than the House's, it is still significantly below the President's request. The President has proposed discretionary spending limits at levels necessary to serve the American people, including American Indians/Alaska Natives. The Administration has consistently reminded Congress that the allocation to the Interior Subcommittees is insufficient to make the necessary investments in Indian programs.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: The Indian Health Service needs to continue to present the health care needs of Indian people in such a way that our budget is a top priority whenever funding allocation decisions are made. This will include consulting with tribal representatives, and working with staff from HHS, OMB and the Appropriations Committees, to ensure that the information needed to make the most compelling possible case is presented in a timely manner.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: W. Craig Vanderwagen, M.D., Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service, (301) 443-4644

SECTION I: FUNDING/BUDGET ISSUES

#7		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Underfunding of Contract Health Services (CHS) (hospitalizations, and specialized care are unavailable or limited due to high expense).	Earmark funds for CHS and increase contract health funds.	IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation-Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The IHS will continue to use the fiscal intermediary (Blue Cross and Blue Shield of New Mexico) to process and pay the majority of CHS claims. The IHS will continue to recommend to tribes to use the IHS CHS FI to process and pay their CHS claims because it could increase the amount of services that they can purchase by approximately 300 percent to 400 percent. To evaluate various options such as a percent of billed charges versus using the Medicare methodology to determine which method would be most advantageous. In FY 1998, the IHS was able to purchase over two to three times the actual amount

paid. The IHS paid $173.8 million for total billed services of $378.4 million. This was accomplished by contractual savings of $124.9 million and alternate resource payments of $79.6 million. The actual savings were greater because these amounts do not include the Medicaid payments that are generally considered to be payment in full. The savings to most tribes should be greater than the savings obtained by the IHS because the tribes will also greatly benefit from the reduction in payment of claims that are paid more than once. The goal is to obtain more IHS and more tribal contracts/rate quotes to purchase CHS at a discount. The IHS continues to support the passage of legislation which requires as a condition of participation in the Medicare program, hospitals which furnish in-patient care to IHS patients, whose care has been authorized pursuant to 42 CFR 36.23 et seq. {1986}, must accept Medicare-like rates as determined by IHS as payment in full. The Office of Inspector General's report, "Review of the Indian Health Service's Contract Health Services Program" supports the passage of this legislation. More health services could be purchased if the money appropriated for CHS was increased. According to the Final Report "Level of Need Funded-model for Areas and States" IHS developed with I&M Technologies Inc. & Center for Health Policy Studies, states that current IHS funding is at national level of need of 59 percent. More health services could be purchased if the money appropriated for the Catastrophic Health Fund was increased. The IHS could use Social Security numbers as the patient identifier so that providers can submit claims electronically without additional programming costs.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

IHS RESPONSE:

- The IHS uses the fiscal intermediary (Blue Cross and Blue Shield of New Mexico) to process and pay the majority of CHS claims.
- The IHS uses alternate resources (other third party payers) when possible to conserve IHS funds.
- The IHS negotiates contracts and rate quotes to obtain discounts that are less than billed charges.
- Providers are able to submit UB 92s electronically to the FI. This expedites payments to providers and reduces processing costs.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

IHS RESPONSE:

Year	Funding	
2000	$406,756,000	
2001	$447,672,000	(This is the amount that was requested. It includes an additional $6 million for the CHEF program.)

5. **Obstacles to addressing issue/issue area:**

IHS RESPONSE: Despite the change from Federal deficits to Federal surpluses the budget caps established by the Balanced Budget Act of 1997 remain in affect through FY 2002. The FY 2001 budget allocation provided for the House Interior Appropriations Subcommittee was $302 million below the FY 2000 level and $1.7 billion less than the amount requested by the Administration. While the Senate Interior Subcommittee has received a budget allocation that is greater than the House's, it is still significantly below the President's request. The President has proposed discretionary spending limits at levels necessary to serve the American people, including American Indians/Alaska Natives. The Administration has consistently reminded Congress that the allocation to the Interior Subcommittees is insufficient to make the necessary investments in Indian programs.

6. **Strategies to overcome obstacles:**

IHS RESPONSE: The Indian Health Service needs to continue to present the health care needs of Indian people in such a way that our budget is a top priority whenever funding allocation decisions are made. This will include consulting with tribal representatives, and working with staff from HHS, OMB and the Appropriations Committees, to ensure that the information needed to make the most compelling possible case is presented in a timely manner.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

IHS RESPONSE: Harry Rosenzweig, Contract Health Service, Office of Public Health, Indian Health Service, (301) 443-2694

SECTION I: FUNDING/BUDGET ISSUES

#8		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Underfunding of environmental health; Emergency Medical Services (EMS); long-term elderly care; after care services; alcohol/ substance abuse programs; diabetes programs; prevention, intervention, and health education programs; and outreach efforts. Refer to Section IV, Issue 2	• Appropriate additional funds for EMS or identify other support for tribal EMS. • Seek line item authorization for elder care. • Appropriate funds for alcohol prevention and treatment. • Commit to long-term diabetes initiative.	ACF, AOA, CDC, HCFA, HRSA, IHS, SAMHSA

1. Public Law(s) or authorization related to this issue/issue area:

ACF Response: There is no ACF program authority that provides funding for health services except where it is an integral part of the program such as Head Start.

- Head Start Performance Standards (45 CFR 1304) require a health component designed to foster healthy development in low-income children primarily through prevention and referral services.

- The Native American Programs Act of 1974, as amended (ANA) does not authorize funds for health services. It does authorize funds for a wide range of social development – including cultural preservation, economic development and governance projects aimed at improving the quality of life for Native American communities.

IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

AOA RESPONSE: ; OAA Title VI (Timeline – long term/ongoing)

HCFA RESPONSE: ; (NOTE: Also Refer to Issue 5 -- Preventive Services)
Several of the services noted above are covered under HCFA's programs. Medicaid payments for outreach may be covered at section 1902(a)(55) of the Act. Under this authority, States may receive Federal matching for outstationing eligibility workers at hospitals that serve a disproportionate number of Medicaid and Medicare patients or at federally qualified health centers (FQHCs), including those on Tribal lands. Section 2102 of the Balanced Budget Act (BBA, P.L. 105-33) requires States to provide procedures for outreach to families likely to be eligible for the State Children's Health Insurance Program (SCHIP). Section 1905(a)(13) of the Social Security Act permits States, at their option, to cover preventive services. Authority for Medicaid coverage of long term elder care is found at two sections of the Act: 1905(a)(4)(A) requires States to cover nursing facility care for eligible individuals age 21 and over, and section 1915(c) permits states, at their election, to establish home and community based services waivers to serve elderly and disabled populations. Additionally, subtitle J of the BBA (P.L. 105-33) transfers $30 million from SCHIP in each fiscal year beginning 1998-2002 to provide special grants for prevention and treatment of diabetes among Indians. IHS administers the grants. HCFA defers to the other OPDIVs listed to address the concerns involving emergency medical services, intervention, after care, substance abuse prevention programs, and environmental health.

CDC RESPONSE: (NOTE) There is considerable overlap between this Issue/Issue Area and Issue #5. In the latter, we have outlined most CDC activities that would also be applicable to this Issue/Issue Area (e.g., diabetes programs, various

prevention/health education programs). Public Health Service Act, particularly Title III, General Powers and Duties of the Public Health Service.

HRSA RESPONSE: Section 1910 of the Public Health Service Act (Emergency Medical Services for Children).

SAMHSA RESPONSE: 42 USC 300x ; and 42 USC 290aa.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
ACF RESPONSE: N/A

IHS RESPONSE: **EMS:** The agency will continue to identify the need for ambulances and trained staff, to address EMS needs and work with other Federal agencies with resources in this area in order to enhance EMS services available to Indian people. (i.e., National Highway Traffic Safety Administration and HRSA). **Elder Care:** The agency will to continue to advocate for the needs of elders through more effective identification of needs, identification of efficient and effective interventions, and collaborative resource acquisition. **Alcohol:** The agency will work with tribes (more than 90% of alcohol funds are administered by tribes) to evaluate the effectiveness of the alcohol activities currently funded. The agency proposes to assure that the appropriate enhancements are identified and resources sought. **Diabetes:** The agency proposes to continue advocacy for continued focus and resources for diabetes on a long-term basis working with congressional staff, OPDIVs of HHS (CDC and NIH), and professional organizations (e.g. American Diabetes Assoc.)

AOA RESPONSE: AoA will work with the Tribes to assure appropriate meals and on-site nutrition and health education targeted at weight management and dietary treatment of diabetes. These services are provided at the senior centers to improve health and eliminate health disparities. Additionally, AoA will encourage Title VI program directors to coordinate with Public Health Nurses and other health care providers to provide diabetes screening, education, and blood pressure and blood glucose monitoring for elders at the senior centers.

HCFA RESPONSE: To the extent that HCFA programs provide coverage for the services listed, funding is provided under Titles XVIII, XIX and XXI of the Social Security Act.

HRSA RESPONSE: see response to question #3 below.

SAMHSA RESPONSE: SAMHSA will continue its SAPT Block Grant and discretionary program funding. CSAP has contracted with an American Indian trainer to develop a model on how adults can work in a collaborative positive youth development mode with American Indian youth. The trainer will also develop a workshop for presenting the model. CSAP is continuing to undertake and implement the recommendations made by their American Indian Substance Abuse Prevention Work Group. TCU administrative grant representatives will be invited to participate in all SAMHSA-sponsored technical assistance workshops relating to enhancing competitiveness for funding of substance abuse and mental health prevention activities.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

- HS

Although there is no prescribed amount of funds within a HS grant to address the health component, the HS program does address some health issues through inter-agency collaboration.

The Head Start Bureau (HSB) has an inter agency agreement with the Indian Health Service which transfers funds to the Environmental Health Services section to inspect tribal Head Start Program/Centers for health and safety matters relating to the Centers. During FY 2000, IHS and the American Indian Programs Branch/HSB has been rewriting a model code for environmental health services. Tribal governments/grantees will be invited to comment on the code. The code will be finalized and tribal governments will be encouraged to use the code as a safeguard for the facilities attended by Indian Head Start children. In addition the HSB has an inter agency with IHS regarding outreach for the Children's Health Insurance Program.

- ANA

In the past and currently ANA has funded projects through inter agency agreements that deal with alcohol prevention and intervention as well as health education. ANA has partnered with HS, SAMHSA, BIA and IHS in this area. ANA competitive grant funds can be used for strategic planning such as for long term care, health education especially as related to environmentally related health issues, and capacity building such as counselor certification in the area of alcohol and substance abuse. In recent years ANA has funded a strategic planning grant for a long-term care facility. ANA funds however can not be used for provision of health services. (See issue #15)

In addition there is no specific competitive grant area for alcohol prevention related projects. ANA grant applications are community designed reflecting the Tribe's or Native American community's priorities. ANA does not prescribe specific areas of funding.

IHS RESPONSE: **EMS:** The agency maintains a roster of ambulances and replacement dates for the equipment. The agency has an Inter-Agency Agreement with the Veterans Administration to provide training for staff. The agency has provided support to the Native American EMS Association to enhance training and advocacy for EMS issues in Indian Country. **Elder Care:** The agency has undertaken an initiative to address elder issues with 3 staff dedicated to the effort. The agency has collaborated with and supported the National Indian Council on Aging in analyzing the needs of elders and advocacy for resources targeting these needs. The agency has joined with NICOA in redressing some issues related to M/M eligibility and the failures in at least one State program. The staff has identified many cost effective and manageable interventions for elder care in the community, and, is providing training and support on a national level to the development of local elder care teams. **Alcohol:** The agency has worked with tribes to develop a more comprehensive definition of alcohol services in the draft language for the reauthorization of the Indian Health Care Improvement Act. The agency has worked with the Youth Regional Treatment Centers to evaluate the efficacy of the programs and identify linkages with community aftercare services. The agency has worked closely with the Department of Justice to improve case finding and treatment programs for juveniles in trouble with the law who may have alcohol related illness. The agency has placed an Indian alcohol specialist with the Center for Substance Abuse Treatment to advocate for resources targeting Indian Country. **Diabetes:** The agency has proposed increases in the FY 2001 budget to assure recurring funds are available to support the new diabetes activities funded by the BBA of 1999 to assure long-term availability of these programs. The agency has worked with NIH to expand tribal participation in research planning and design targeting Indian Country. The agency has worked with tribes to develop the Diabetes Prevention Research Center in New Mexico to assure long-term evaluation of the most effective prevention interventions.

AOA RESPONSE: AoA currently provides training to new Title VI directors on menu planning, basic nutrition, coordination, and outreach methods. On-site program monitoring visits include training and technical assistance on various aspects of the program, including coordination with other programs.

HCFA RESPONSE: All Medicaid programs must provide long term care in nursing facilities for persons age 65 and older. Additionally, States have the option of seeking home and community based waiver programs and other optional services, which can be used to provide long- term, care in a community setting. HCFA has provided technical assistance to both the Tribes and States in their efforts to test the feasibility of developing long-term care programs targeted at Native American people. HCFA has also let contracts to provide information about its major programs. For example, HCFA has funded projects with Salish Kootenai Tribal College to develop outreach materials for the SCHIP and the program serving individuals dually eligible for Medicare and Medicaid. HCFA has funded a larger initiative that produced outreach materials for elderly and disabled AI/ANs potentially eligible for both Medicare and Medicaid. Additionally, on February 24, 1998, HCFA and HRSA, sent a joint letter to all States encouraging them to improve outreach efforts and establish health services initiatives to benefit AI/AN children under their SCHIP plans.

HRSA RESPONSE: Two HRSA programs could involve emergency medical services: the Trauma/EMS program and the Emergency Medical Services for Children Program. The Trauma/EMS program has no grants at present. HRSA has various initiatives to assist tribes in participating in the Emergency Medical Services for Children. For instance, all States with identified Native American populations currently have an EMSC grant. In South and North Dakota, for example, the EMSC project officers work directly with tribes and tribal organizations in their states to support pediatric emergency medical training, technical assistance, and direct injury prevention interventions. Further, HRSA has an interagency agreement with the Indian Health Service to enhance the quality of services and training for Native American EMS programs throughout the U.S. This agreement provides support for expert medical direction, training, and other services to more than 100 tribal EMS programs

SAMHSA RESPONSE: The Substance Abuse Prevention and Treatment (SAPT) Block Grant is the main funding mechanism for alcohol and drug abuse services from SAMHSA. These funds are provided to States according to a congressionally-mandated formula, which is used to serve all populations according to a state-determined allocation mechanism. Legislative language does not specify services to subpopulations, except for pregnant women and those suffering from or at risk for HIV/AIDS. Alcohol and drug abuse funding is also provided under the discretionary programs of SAMHSA's Center for Substance Abuse Treatment, Center for Substance Abuse Prevention, and Office of Minority Health MH) CSAT provides service funds under its Targeted Capacity Expansion (TCE) and Knowledge Development and Application (KDA) grant programs. Funding for American Indian/Alaska Native populations has been targeted under the TCE program and successfully accessed by tribes in recent years. For FYs 1998 and 1999 tribes received over $11 million. TCE grants provide the opportunity for state and communities to build capacity to deliver effective, science-based services, often meeting needs otherwise left unaddressed. The target groups are substance abusers and their families in need of substance abuse treatment as provided in residential, day or outpatient programs. In FY 1999, funding in the amount of $10,000 was provided by CSAP to the Native American Research Information System (NARIS), operated by the American Indian Institute at the University of Oklahoma. This database provides information on the research literature pertaining to American Indian substance abuse and prevention.

CSAP

Literature review and national search for best and promising practices in AI/AN prevention programs: Using a national registry format, an American Indian graduate student at CSAP's Western Center for the Application of Prevention Technology (CAPT) is contacting AI/AN prevention programs and obtaining program information and evaluation results where they exist. This search will help CSAP recommend effective Native programs for American Indians/Alaska Natives. The student is also organizing a library of materials and curricula from a number of Indian substance abuse prevention programs. These will be reviewed by an AI/AN expert panel In July 2000, the quality of the results of the programs will be rated, and the information will be disseminated.

The 7th Generation Communications Prevention Demonstration Project: This 1996-1998 CSAP project was administered by the American Indian Institute, College of Continuing Education, University of Oklahoma. The project's overall goal was to develop national education and prevention communications strategies to prevent Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). The target audience included American Indian children, youth and young adults ages 8-25. Two award winning videos were developed for this project along with a number of culturally oriented materials including a curriculum guide. In FY 1999, CSAP funded the American Indian Substance Abuse Performing Troupe through UNITY, a national American Indian youth organization. Members of the troupe spent a year learning dance routines and preparing a performance. Together with their families, they jointly made their costumes and built the stage sets for the performance, which was held at the Kennedy Center in Washington, DC, in February 2000. An American Indian monograph will soon join CSAP's Cultural Competency Series of publications. Each chapter was written by an American Indian researcher. The monograph is currently being published and will be formally released on July 10, 2000. The target audience is all healthcare professionals who work with or in American Indian/Alaska Native communities.

In FY1999, CSAP developed an American Indian Substance Abuse Prevention Work Group which advised CSAP about positive actions to undertake and products that American Indians/Alaska Natives needed in order to plan and implement prevention activities in their communities. Discussions throughout the year on American Indian issues served to educate and raise the consciousness of CSAP staff. Major national Indian service organizations were represented in the group. In 1994, a Gathering of Native Americans (GONA) substance abuse prevention curriculum and manual were developed by CSAP by means of a team of American Indian/Alaska Native consultants. The GONA material has become the source of the most frequently requested technical assistance requested by tribes over the past several years. CSAP is publishing 10,000 copies of a revised manual which is smaller and more user-friendly. CSAP maintains a webpage for American Indian/Alaska Natives as part of their PrevLine website (http://www.health.org/multicul/natamer/index.htm). This website is part of the website of the National Clearinghouse for Alcohol and Drug Information (NCADI), a SAMHSA/CSAP contract). The information is changed periodically, and materials can be ordered online. In addition, the website of WestCAPT, another CSAP contractor, has information posted on American Indian/Alaska Native model prevention programs and best practices. See www.unr.edu/westcapt. Contact information for each program is published, as well as information on the components of the program and description of evaluation.

In addition, CSAP has provided funding for a non-profit Indian firm, White Bison, Inc., to post information on their already established and well-known website (www.whitebison.org). The purpose of this unique website is to reduce the burden on tribes

for finding information frequently requested. All American Indian/Alaska Native substance abuse prevention programs past and present are being reviewed for best and promising practices. This information will be posted and linked to the WestCAPT website. Other materials that American Indian communities can download and use in prevention programs include information on grants available from government agencies, instructions on how to apply for a grant, and information on current American Indian/Alaska Native SAMHSA grants. Finally, daily progress of the Sacred Hoop Journey/Walk for Sobriety across the U.S. is being published on the White Bison website. Photos and brief video clips are posted of each day's activities. Also, a videographer is being funded by CSAP to document the Walk, which began in Los Angeles on April 2 and culminates at the White House on July 10.

Office of Minority Health
In FY 1999, SAMHSA's Office of Minority Health provided technical assistance to four TCUs on developing high quality and competitive SAMHSA grant applications.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
ACF RESPONSE: N/A

IHS RESPONSE: There are no line items for elder, EMS, and only partial identification of diabetes funding in the budget activities. The alcohol activity was funded at $96.8M in FY2000 and the President proposed $99.6M for FY2001.

AOA RESPONSE: : AoA has requested a 5 million dollar increase in the Title VI funding for FY 2001. The increased funds will allow Tribes to provide additional services, including nutrition and education.

HCFA RESPONSE: N/A

HRSA RESPONSE: The Trauma/EMS program currently has no Congressional appropriation. The EMSC program was funded at $17 million in FY 00, and $15 million in FY 01.

SAMHSA RESPONSE:
SAPT BG FY 2000: $1.6 billion
SAPT BG FY 2001: $1.631 billion (proposed)
(The amount of SAPT Block Grant funding used by States to serve AI/ANs is not known.)
CSAT total discretionary funding, FY 2000: $114 million
CSAT total discretionary funding, FY 2001: $163 million (proposed)
CSAP AI/AN discretionary funding, FY 2000: $8.2 million
CSAP model and workshop on adults working with American Indian youth - FY 2000 - $24,000
CSAP's Gathering of Native Americans (GONA) manual - FY 2000 - $10,500
CSAP videographer for Sacred Hoop Journey/Walk for Sobriety - FY 2000 - $24,000

5. **Obstacles to addressing issue/issue area:**
ACF RESPONSE:

- ANA – ANA applications are reviewed under a competitive process. Projects are funded for 103 years and must be self-sustaining or completed at the end of the project period, making service delivery projects unallowable. Grant funding for a project is funded only once. The same project can be funded only once, although th enext phase of the project can be funded.

IHS RESPONSE: Prioritization of these programs during the budget formulation process placed the diabetes, elder care, and alcohol activities high in the tribal ranking. EMS was lower in the ranking. Again, the overall budget ceilings meant that these items were not proposed for large funding increases. Authorities for funding from other HHS agencies do not address the needs and realities of Indian Country making it difficult for tribes to access funding from these agencies.

AOA RESPONSE: There is limited Title VI funding available for extensive supportive services.

HCFA RESPONSE: States generally do not design their long-term care programs to recognize the special needs of AI/AN populations. Additionally, many States have been reluctant to outstation eligibility workers at any FQHCs, including those on Tribal lands.

HRSA RESPONSE: Emergency Medical Services legislation limits eligible applicants to States and medical schools.

SAMHSA RESPONSE: In the case of SAMHSA's SAPT Block Grant, while some states provide considerable funding for substance abuse prevention and treatment services to AI/AN populations, other states provide little funding. TCUs may lack adequate capacity and/or infrastructure resources to support prevention program efforts that are necessary to successfully compete for SAMHSA grants. Most TCUs are two-year programs.

6. **Strategies to overcome obstacles:**
ACF RESPONSE: N/A

IHS RESPONSE: The agency is working with other HHS agencies to assess changes needed to enhance Tribal access to resources including legislative strategies for changing basic authorities.

AOA RESPONSE: : AOA will encourage Tribes to provide as many services as possible at the senior centers, encourage senior programs to provide outreach to homebound elders, and work with them to enhance their coordination with other programs.

HCFA RESPONSE: Encourage States and Tribes to work in partnership to develop outreach strategies targeted at AI/ANs and to identify and implement approaches for the delivery of long-term care services, mental health services, and other covered services that address the health issues identified.

HRSA RESPONSE: Providing more information to tribes on these HRSA programs.

SAMHSA RESPONSE: Work with states to assess tribal needs for substance abuse services. Provide necessary technical assistance and consultation to overcome barriers to providing such services (such as the perception that Indian Health Service funding is sufficient to meet tribal needs, or that funding may be precluded by sovereignty issues).SAMHSA is working with the American Indian Higher Education Consortium to help build and strengthen capacity and to enhance TCUs' success in grant/contract competition.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
ACF RESPONSE: Vacancy, Chief, American Indian Programs Branch, HSB (202) 205-8437
Jean Luka, Director, Programs Operations Director (202) 690-6324

IHS RESPONSE: W. Craig Vanderwagen, M.D. Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service, (301) 443-4644

AOA RESPONSE: Yvonne Jackson, Director, OAIANNHP (202) 619-2713

HCFA RESPONSE: Joyce Jackson (HCFA), Technical Director – (410) 786-0079, NOTE: This is a long-term, ongoing activity.

HRSA RESPONSE: Dr. David Heppel, M.D., Director of Child, Adolescent, and Family Health, 301-443-2250.

SAMHSA RESPONSE: Steve Sawmelle , Intergovernmental Coordinator , Office of Policy and Program Coordination, (301) 443-0419

SECTION I: FUNDING/BUDGET ISSUES

#9		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Under funding of administrative and indirect funds for compacting and contracting.	Appropriate sufficient funds for administrative and indirect costs to tribes.	IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: Continue consultation and participation with tribes to explain and justify to Congressional and Appropriations Committee members the need for full CSC. Support the reinstatement of ISDA provisions mandating CSC reporting requirements to Congress.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The IHS continues to advocate for full funding of CSC within the budget formulation process and with Congress. The IHS recently adopted a revised policy on CSC after undergoing an extensive tribal consultation process. The policy is intended to ensure equitable distribution of any funding made available for CSC.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: CSC appropriations in FY 2000: $229M total. This was a $25M increase over the previous FY 1999 amount, of which $10M was for new and expanded and $15M was for CSC shortfall. Proposed CSC appropriations for FY 2001: $269M. This is a $40M increase over the FY 2000 amount, of which an estimated $12.5 will be for new assumptions. The amount could be higher since contracting and compacting is a tribal option. The balance will be utilized to address unmet CSC need for existing contracts/compacts.

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: Despite the change from Federal deficits to Federal surpluses the budget caps established by the Balanced Budget Act of 1997 remain in affect through FY 2002. The FY 2001 budget allocation provided for the House Interior Appropriations Subcommittee was $302 million below the FY 2000 level and $1.7 billion less than the amount requested by the Administration. While the Senate Interior Subcommittee has received a budget allocation that is greater than the House's, it is still significantly below the President's request. The President has proposed discretionary spending limits at levels necessary to serve the American people, including American Indians/Alaska Natives. The Administration has consistently reminded Congress that the allocation to the Interior Subcommittees is insufficient to make the necessary investments in Indian programs.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: The Indian Health Service needs to continue to present the health care needs of Indian people in such a way that our budget is a top priority whenever funding allocation decisions are made. This will include consulting with tribal representatives, and working with staff from HHS, OMB and the Appropriations Committees, to ensure that the information needed to make the most compelling possible case is presented in a timely manner.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: Ronald Demaray Director, Self-Determination Services, Office of Tribal Programs, Indian Health Service, (301) 443-1104

SECTION I: FUNDING/BUDGET ISSUES

#10		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFF DIVs Assigned Response
Insufficient Appropriations: • IHS funding has not kept pace with inflation, growth of Indian population, or level of health service needs. • Lack of funding and underfunding of services	• Adjust the Indian Health Care Improvement Act that authorizes the IHS improvement fund for equity funding.	IHS

force tribes/members to use funds from other sources to cover budget shortfall. • Inequitable funding across tribes/areas (per capita allocation). • Inadequate allocation formula – use of current services provided does not allow for expansion of services or equalization of services provided. • Inadequate funding level puts undue financial responsibility on tribes and tribal members.		

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: Improve collaborative advocacy by the IHS, Tribes and Urban Indian Health leadership by using the annual budget formulation process to identify and set top health priorities. Identify a broad strategy for "maintenance of access to care and closing the health disparity" when advocating for the need to fund Indian health programs. Continue including Tribal leadership in annual budget formulation process. Tribal leaders identify target funding to meet health care needs of American Indians and Alaska Natives. In follow-up to P.L. 94-437 reauthorization consultation, an analysis of options for funding Indian health programs is planned. A study is underway to examine health-funding parity for Indian people compared to the Federal Employees Health Benefit Plan. This study, known as the Level of Need Funded (LNF) study, uses actuarial methods to estimate the costs of a mainstream benefits plan for Indians. Consultation with Indian tribes is still ongoing about the possibility of using LNF study results in new resource allocation formulas to address inequities within Indian country.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: Use the national I/T/U budget formulation process to address more effective ways to advocate for inflation, population growth, other current service items and the closing the health disparity gap.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

IHS RESPONSE:	FY 2000	FY 2001 Estimate
IHS BUDGET AUTHORITY	$2,390,728,000	$2,620,429,000
IHS COLLECTIONS	$439,290,000	$439,290,000
TOTAL IHS PROGRAM LEVEL	$2,830,018,000	$3,059,719,000

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: The Indian population continues to expand a rate exceeding the rate of growth for other Americans. Health is disproportionately lower among Indians - Indians experience higher rates of mortality and morbidity compared to the US All Races rates. Persons in poor health need more services and, often, more complex services. This increases the costs per person. Funding is not directly tied to number of beneficiaries or health conditions. The number of Indians seeking health care services often exceeds the capacity of the Indian health system. Additionally, the range of available services, particularly more complex services, is limited and insufficient. Allocation of resources predominantly follows historical patterns – initially earmarked by Congress for individual facilities or programs. Tribes are extremely reluctant redistribute base funding because of widespread resource insufficiency.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: Continue working with tribal leadership in budget formulation to identify funding needs and in setting resource allocation policy. Examine the feasibility, benefits and costs of entitlement based funding. Continue consulting with tribal leadership to implement IHS funding formulas that address inequities found among IHS Areas and tribes. Continue to present the need for these costs by describing the need in basic health care services.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: Budget Formulation Issues: June Tracy, 301-443-7261, Allocation Issues: Cliff Wiggins, 301-443-7261

SECTION I: FUNDING/BUDGET ISSUES

#11		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFF DIVs Assigned Response
• Oppose moratorium on 638 activities. • Against retroactive extinguishments of claims set forth for "contract support cost" for 1994 and 1997. • Against distribution of funding via pro rata method (CSC). • Takes 5-6 years to receive full funding for operations taken over through the 638 contracting process.		IHS

1. Public Law(s) or authorization related to this issue/issue area:

IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:

IHS RESPONSE:

- (*Oppose moratorium on 638 activities*) The IHS continues to be committed to supporting tribes/tribal organizations in all 638 contracting/compacting activities, and is opposed to any moratorium on contracting and compacting. It is contrary to the ISDA and the Congressional/Administrative policy of promoting self-determination opportunities for Indian people
- *(Against retroactive extinguishment of claims set forth for "contract support cost."* Congress has placed a "cap" on the amount of funding that can be used for CSC during these years.
- *(Against distribution of funding via pro rata method)* The IHS will continue to work with tribes/tribal organizations concerning equitable CSC funding methodologies.
- *(Takes 5-6 years to receive full funding for operations taken over through the 638 contracting process)* The IHS will continue to work with tribes/tribal organizations, the Administration, and Appropriation Committee(s) to advocate for full funding for IHS contractors and compactors.

3. OPDIV/STAFFDIV activities to date on this issue/issue area:

IHS RESPONSE:

- (*Oppose moratorium on 638 activities*) On November 29, 1999, IHS appropriation 3194, the Consolidated Appropriations Act for FY 2000 was signed into law, in effect lifting the previous FY moratorium on 638 contracting.
- (*Against retroactive extinguish of claims*) The IHS is presently involved in litigation concerning CSC claims from past years.
- *(Against distribution of funding via pro rata method)* Both the Department and the IHS have gone on record opposing any pro-rata distribution of any CSC funding. The IHS' new CSC policy, however, does incorporate pro-ration as a method of allocating all "new and redistributed" CSC funds in such a way as to provide the greatest increases proportionately to those tribes with the greatest CSC shortfalls in order to further reduce the disparity in CSC funding levels among all tribes in the IHS system
- *(Takes 5-6 years to receive full funding for operations taken over through the 638 contracting process)* In addressing the inequity in CSC funding levels of tribes in the IHS system, the IHS' CSC policy was recently revised through extensive consultation and coordination with American Indians/Alaska Natives. The new CSC policy abandons the historic approach to the Indian Self-Determination (ISD) Fund and the maintenance of a queue system in favor of a pro rata system whereby each eligible tribe with an ISD Fund request receives additional funding proportionate to its overall CSC needs. Those with the greatest unfunded CSC needs will receive the greatest increases in ISD funding under the new policy. The CSC shortfall funding will also be distributed on a similar pro rata basis by providing the greatest CSC increases to those tribes with the greatest CSC increases to those tribes with the greatest unmet CSC needs.

4. Appropriations information related to the issue/issue area (FY00, FY01):

IHS RESPONSE: CSC appropriations in FY 2000: $229M total. This was a $25M increase over the previous FY 1999 amount, of which $10M was for new and expanded and $15M was for CSC shortfall. *Estimated* CSC appropriations for FY 2001: $269M. This is a $40M increase over the FY 2000 amount, of which an estimated $12.5 will be for new assumptions.

The amount could be higher since contracting and compacting is a tribal option. The balance will be utilized to increase CSC funding for existing contracts.

5. **Obstacles to addressing issue/issue area:**

IHS RESPONSE: Despite the change from Federal deficits to Federal surpluses the budget caps established by the Balanced Budget Act of 1997 remain in affect through FY 2002. The FY 2001 budget allocation provided for the House Interior Appropriations Subcommittee was $302 million below the FY 2000 level and $1.7 billion less than the amount requested by the Administration. While the Senate Interior Subcommittee has received a budget allocation that is greater than the House's, it is still significantly below the President's request. The President has proposed discretionary spending limits at levels necessary to serve the American people, including American Indians/Alaska Natives. The Administration has consistently reminded Congress that the allocation to the Interior Subcommittees is insufficient to make the necessary investments in Indian programs.

6. **Strategies to overcome obstacles:**

IHS RESPONSE: The Indian Health Service needs to continue to present the health care needs of Indian people in such a way that our budget is a top priority whenever funding allocation decisions are made. This will include consulting with tribal representatives, and working with staff from HHS, OMB and the Appropriations Committees, to ensure that the information needed to make the most compelling possible case is presented in a timely manner.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

IHS RESPONSE: Ron Demaray Director, Self Determination Services, Office of Tribal Programs, Indian Health Service, (301) 443-1104

SECTION I: FUNDING/BUDGET ISSUES

#12		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Inequitable funding for Indian population as compared to other U.S. populations (fairness of appropriation of funds across HHS-proportional share).	• Fully involve tribes in the budget process • Budget discussions should include discussion about changes in legislative language.	All OPDIVs/STAFFDIVs

1. **Public Law(s) or authorization related to this issue/issue area:**

IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

AOA RESPONSE: President's memorandum of April 29, 1994 titled, "Government to Government Relationship with Native American Tribal Governments and Executive Order No. 13175 ensures consultation.
(Timeline – long term/ongoing)

HCFA RESPONSE: N/A

AHRQ RESPONSE: N/A

CDC RESPONSE: Public Health Service Act, particularly Title III, General Powers and Duties of the Public Health Service.

HRSA RESPONSE: Office of Minority Health = N/A

IGA RESPONSE: President's Memorandum of April 29, 1994 – "Government-to-Government Relationship with Native American Tribal Governments". President's Exectuive Order 13084 of May 14, 1998, "Consultation and Coordination With Indian Tribal Governments". HHS "Policy on Consultation with American Indian and Alaska Native Tribes and Indian

Organizations; and Executive Order 13175 of November 6, 2000, Consultation and Coordination With Indian Tribal Governments.

SAMHSA RESPONSE: 42 USC 290aa, 42 USC 290ff, 42 USC 300, 42 USC 300x

ACF RESPONSE: see Section V, Issue 7 and see ACF Program Chart at the end of this matrix.

FDA RESPONSE: N/A

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:

IHS RESPONSE: The Indian Health Service includes Tribal leadership in its annual budget formulation process. Tribal leaders identify target funding to meet health care needs of American Indians and Alaska Natives. In a comprehensive process, tribal leadership worked to reach consensus on key policy issues for reauthorization of the Indian Health Care Improvement Act P.L. 94-437. In follow-up to P.L. 94-437 reauthorization, a comprehensive analysis of Indian health programs as "entitlement" is planned. A study is underway to examine health-funding parity for Indian people compared to the Federal Employees Health Benefit Plan. This study, known as the Level of Need Funded (LNF) study, uses actuarial methods to estimate the costs of a mainstream benefits plan for Indians. Consultation with Indian tribes is still ongoing. The IHS is consulting with Indian tribes about the possibility of using LNF study results in new resource allocation formulas to address inequities within Indian country.

AOA RESPONSE: AoA held a Tribal Listening Session in August, 2000. Tribal officials were able to express their concerns/comments/ideas.

HCFA RESPONSE: Consultation with the Tribes will be necessary to develop strategies to address those issues raised during the HHS budget process.

AHRQ RESPONSE: Per AHRQ's draft tribal consultation plan, AHRQ plans to take part in the Department's annual budget meetings with the tribes to identify tribal desires regarding AHRQ (AHRQ participated in the first two annual meetings). As needed, i.e., when AHRQ is considering undertaking activities of particular import/interest to tribes, and if the timing is appropriate, AHRQ may request time at the departmental tribal budget consultation meetings to make presentations to the assembled tribal group to get feedback and input for its budget process. Alternately, AHRQ may send information on special initiatives to tribes in advance of the annual meeting and ask the assembled tribal group for feedback.

CDC RESPONSE: Conduct an annual, CDC-wide AI/AN Budget Planning and Priorities Meeting; Once completed, fully implement a new CDC Tribal Consultation Policy; Many cooperative agreement and grant announcements for prevention programs issued by CDC include federally recognized Indian tribal governments among the eligible applicants. Examples from FY 2000 include:

- An RFP which will provide funding for violence against women prevention services to underserved populations has been released;
- An RFP has been released which will provide funding for unintentional injury prevention programs, including programs to increase booster seat use among children riding in motor vehicles, a demonstration program to reduce falls among older adults, programs to prevent fire and fall-related injuries in older adults, multifaceted teen and young adult bicycle safety programs; and multifaceted programs for the prevention of dog bite related injuries;
- An RFP which will provide funding for core state injury surveillance and program development has been released;
- An RFP which will provide funding for surveillance of intimate partner violence has been released;

CDC announced the availability of FY 2000 supplemental funds to strengthen programs to prevent risk behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancy among Native American/Alaskan Native youth under Program Announcement 805, "School Health Programs to Prevent Serious Health Problems and Improve Educational Outcomes." Eligible applicants are those State Education Agencies (SEAs) currently funded under Part I of Program Announcement 805 with more than 4500 Native American/Alaskan Native youth in their public schools (as cited by the 1999 U.S. Department of Education, Title IX Indian Education Formula Grant Program)and includes Alaska, Arizona, California,

Michigan, Minnesota, Montana, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, and Wisconsin.

HRSA RESPONSE: HRSA is planning to hold a budget meeting in 2001, prior to submission of our FY 2003 budget to Congress to obtain tribal input.

IGA RESPONSE: IGA will continue the Department's annual budget meetings with American Indians and Alaska Natives to present their appropriation needs and priorities before the submission by OPDIVs/STAFFDIVs of their budget requests to the department (May of each year).

ACF RESPONSE: See question 4 below.

FDA RESPONSE: N/A

SAMHSA RESPONSE: SAMHSA will continue to provide technical assistance workshops to advise and assist potential applicants for discretionary grants, and tribes are eligible to attend these workshops.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: -- see #2 above --
AOA RESPONSE: AoA convened a planning meeting on May 11 and 12, 2000 with AoA Regional representatives, Tribal organizations and Native American Resource Centers to discuss and develop the upcoming Tribal Listening Session. AoA has participated in the HHS wide Tribal Consultation meetings on the budget the past two years. Both years the Tribes have recommended increased funding for Title VI. In response to these meetings, discussions with Title VI grantees, and visits to Tribal programs, the Administration's 2001 budget request includes a 5 million dollar increase in funding for Title VI.

HCFA RESPONSE: HCFA participated in the April 10, 2000 HHS budget consultation and is currently examining the tribal recommendations.

AHRQ RESPONSE: AHRQ has participated in the first two annual departmental tribal budget sessions. AHRQ currently conducts health services research and, in particular, research on how to improve quality of care, that addresses the needs of all Americans. Research in such areas as diabetes is particularly relevant to Native American populations. Also of particular import to Native Americans is AHRQ's work in health care disparities—identifying and explaining the reasons for observed disparities. AHRQ has engaged in numerous initiatives over the last several years to promote the interests of Native Americans as defined by tribes, including a health services research agenda-building conference in 1996 and development of a draft tribal consultation plan. The agenda-building conference included significant tribal consultation. AHRQ has been active in the Tribal College and University Initiative, taking a leading role on the working committee and the group that planned the January 1999 national conference. AHRQ has also been active in the departmental tribal consultation initiative and served on the small workgroup that developed the departmental plan. AHRQ has participated in numerous departmental and Indian Health Service (IHS) initiatives to identify and promote tribal health interests, such as the "Crafting the Future" conference and taken independent actions, such as meeting with the Kaiser Foundation Indian Health Policy Fellows, developing a User Liaison workshop on subjects of import to tribes (to take place during June 2000), and working with the Association of American Indian Physicians to contribute to their August 2000 conference on improving the quality of health care in Indian country. AHRQ has spoken at numerous conferences of import to Native Americans (e.g., the annual IHS research conference), disseminated information on the agency, its work, and particularly relevant "Requests for Applications" to all tribes, and spoken at length with IHS about how AHRQ can help support its research function.

CDC RESPONSE: Conducted first annual AI/AN Budget Planning and Priorities Meeting in Atlanta, March 2000; Re-convened CDC's official Tribal Consultation Policy Group, with representation from all CDC C/I/Os, including CDC staff of AI/AN heritage; Developed two new staff positions within the Office of the Associate Director for Minority Health (OADMH)/Office of the Director (OD)/CDC exclusively committed to AI/AN issues;

HRSA RESPONSE: HRSA participated in the first two Departmental budget meetings to which Indian tribes were invited to testify.

IGA RESPONSE: On August 7, 1997, the Secretary issued the HHS "Policy on Consultation with American Indian and Alaska Native Tribes and Indian Organizations" that provides for an annual meeting of Indian people to present their appropriation needs and priorities. The Office of Intergovernmental Affairs (IGA), IHS, ANA, and the Office of Minority Health (OMH) are to convene this annual meeting before the submission by HHS agencies of their budget requests to the department (in May of each year). IGA coordinated the first Budget Consultation meeting between HHS and tribal governments on May 4, 1999; and the second was held on April 18, 2000. The Assistant Secretary for Management and Budget and other members of the department's Budget Review Board were present.

SAMHSA RESPONSE: Some discretionary grants are specifically available to tribal governments, along with units of state governments and territories. Tribal organizations are eligible to apply for discretionary grants available to nonprofit and profit making organizations, to develop and apply new knowledge in the mental health and substance abuse fields.

ACF RESPONSE: The HHS "Policy on Consultation with American Indian and Alaska Native Tribes and Indian Organizations" was issued on August 7, 1997. This policy provides for budget consultation through "an annual meeting of Indian people to present their appropriation needs and priorities." ANA, an ACF program component is designated as one of the four HHS agencies to organize the annual budget consultation meeting.

FDA RESPONSE: N/A

4. Appropriations information related to the issue/issue area (FY00, FY01):
IHS RESPONSE:

	FY 2000	FY 2001 Estimate
IHS BUDGET AUTHORITY	$2,390,728,000	$2,620,429,000
IHS COLLECTIONS	$439,290,000	$439,290,000
TOTAL IHS PROGRAM LEVEL	$2,830,018,000	$3,059,719,000

AOA RESPONSE: The Administration's 2001 budget request includes a 5 million dollar increase in funding for Title VI. The Senate 2001 budget has the 5 million dollar increase. However, the House 2001 budget provides for no increase.

HCFA RESPONSE: N/A

AHRQ RESPONSE: FY00--Separately identifiable money: $16,000 for Tribal College Interns and $ 180,000 for the User Liaison Program workshop on issues of import to Indian health care systems. AHRQ is also sending one of its most senior officials to Navajo this summer for several weeks to treat patients and teach.

CDC RESPONSE: FY 2000: no specific appropriations for budget consultation, utilized existing OD and C/I/O funds to support the March 2000 AI/AN Budget Planning and Priorities Meeting;
FY 2001: OADMH developed a broad-based AI/AN-specific budget initiative; initiative failed; FY 2002: New AI/AN budget initiative under development to broadly support public health infrastructure within AI/AN communities;

HRSA RESPONSE: N/A

IGA RESPONSE: There are no appropriations for Consultation initiatives.

SAMHSA RESPONSE: N/A (Appropriations information provided under issue areas related to discussions of specific programs.)

ACF RESPONSE: The President's FY 2001 ACF budget contains over a 14 million-dollar increase for ACF tribal programs. This includes a $9 million increase for ANA for a total proposed funding level of $44,420. There is also a one-time $5 million increase proposed for a new program to help improve Indian tribal child welfare programs. This initiative calls for the Secretary to conduct a comprehensive assessment to identify the strengths and challenges faced by Indian Tribes operating child welfare programs and meeting title IV-B protections and potentially title IV-E requirements with regard to Indian children. This initiative will also provide funding, on a competitive basis, for a limited number of Indian Tribes that receive title IV-B funds to improve their capacity to operate child welfare programs. Specific areas to be addressed include data collection and reports, program administration and case management, licensing and criminal background checks for prospective foster and adoptive

parents, improvement of the case review system, and training and retention of child welfare staff. The ACF Tribal Initiative also proposes 9 additional staff to support tribal programs in child support enforcement and tribal TANF.

FDA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**

IHS RESPONSE: The Indian population continues to expand a rate exceeding the rate of growth for other Americans. Health is disproportionately lower among Indians - Indians experience higher rates of mortality and morbidity compared to US All Races. Persons in poor health need more services and, often, more complex services. This increases costs per person. Resources are not tied to number of beneficiaries or health conditions. The number of Indians seeking health care services often exceeds the capacity of the Indian health system. Additionally, the range of available services, particularly more complex services, is limited and insufficient. Allocation of resources predominantly follows historical patterns – initially earmarked by Congress for individual facilities or programs. Tribes are extremely reluctant redistribute base funding within Indian country because of widespread resource insufficiency.

AOA RESPONSE: Increased appropriations.

HCFA RESPONSE: Some of the recommendations may require legislation.

AHRQ RESPONSE: HHS has now forwarded all of the OPDIVs'/STAFFDIVs' plans to OMB. The need to consult with all 550+ federally recognized tribes will be a challenge for AHRQ, which is a small agency with no field operations.

CDC RESPONSE: Inadequate funding/staffing specifically earmarked for AI/AN populations;; Lack of awareness/understanding by many CDC staff regarding special relationships with /obligations to AI/AN communities; Few applications received by tribes and tribal organizations for those program announcements for which they are eligible;

HRSA RESPONSE: Tribes need to know about HRSA programs and understand HRSA's mandates and legislation.

IGA RESPONSE: Tribal perspective in the HHS Budget process needs to be included during OPDIV heads meetings with ASMB. The Senior Advisor Tribal Affairs will not be able to carry out all aspects of the requirements of the HHS Consultation Policy alone. Additional, appropriate staff is required to fulfill the commitments specified by the policy.
SAMHSA RESPONSE: Perception that Indian Health Service and the Bureau of Indian Affairs provide for all health needs of the tribes.

ACF RESPONSE: Obstacles depend on the outcome of the FY 2001 appropriations.

FDA RESPONSE: N/A

6. **Strategies to overcome obstacles:**

IHS RESPONSE: Continue working with tribal leadership in budget formulation to identify funding needs and to consult on resource allocation policy. Examine the feasibility, benefits and costs of entitlement based funding. Continue consulting with tribal leadership to implement IHS funding formulas that address inequities found among IHS Areas and tribes.

AOA RESPONSE: Include budget increases in AoA's budget submission.

HCFA RESPONSE: Further consultation with the Tribes will be the basis for our strategies, including the provision of technical assistance to facilitate Tribal access to HCFA programs and/or the development of legislative remedies.

AHRQ RESPONSE: Strategies to overcome obstacles: First, once the tribal consultation plan is vetted with the tribes, AHRQ will send all federally-recognized tribes information about the agency to familiarize them with us and what we do. AHRQ will welcome feedback. Then, as needed and appropriate, AHRQ will send out letters addressing issues requiring consultation to all 550+ tribes. Use may also be made of the AHRQ web site as well as that of IHS and perhaps others that are regularly consulted by many tribal officials. AHRQ will apprise all federally recognized tribes of decisions on matters for which consultation was sought. As appropriate, AHRQ may also make use of the annual departmental budget consultation meetings to obtain tribal input on budgetary matters (see #2 above).

CDC RESPONSE: Vigorously pursue budget initiatives noted above; Educate CDC staff regarding the Agency's unique relationship with, and special responsibilities to, AI/AN communities; promote AI/AN-specific budget planning throughout CDC; Work to ensure tribal eligibility for all program announcements/funding opportunities developed by CDC, All RFPs are posted in the Federal Register and on the CDC web-site at : http://www.cdc.gov/od/pgo/funding/grantmain.htm; Ensure tribes and tribal/urban Indian organizations are aware of opportunities to acquire prevention funding to establish basic programmatic core capacity to conduct effective community-based prevention programs; CDC will continue to examine its categorical programs to determine if there is any prohibitive language making tribes ineligible to apply for direct funding; CDC will facilitate communication between its C/I/Os to share advice about effective ways to work with tribes and identify effective funding mechanisms to fund tribes to prevent diseases and injury;

HRSA RESPONSE: Inform Tribes about HRSA programs and understand HRSA's mandates and legislation.

IGA RESPONSE: Involve IGA Senior Advisor on Tribal Affairs in OPDIV budget process and meetings held by ASMB. Rationale: Meetings of OPDIV heads by ASMB to defend respective HHS Agency Budgets discuss many important budgetary issues. There are opportunities to comment on and influence budget decisions during these meetings. The IGA Senior Advisor for Tribal Affairs is the highest positioned policy official for tribal matters in the Department. Her direct input to the Department budget process is invaluable to ensuring the tribal perspective in the HHS Budget process, and fully appropriate in keeping with the President's Executive Order 13175. IGA permanently filled the position of the Senior Advisor for Tribal Affairs.

SAMHSA RESPONSE: SAMHSA is making it widely known that it also serves tribes' health needs. It identifies gaps in prevention and service delivery and designs, develops, and implements programs for underserved and at-risk populations.

ACF RESPONSE: ACF will continue to focus on the tribal initiative begun with the preparation of the FY 2001 ACF budget and the hosting of the ACF Tribal Forums.

FDA RESPONSE: N/A

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
IHS RESPONSE: Legislative Issues: Michael Mahsetkey, 301-443-7261, Budget Formulation Issues: June Tracy, 301-443-7261, Allocation Issues: Cliff Wiggins, 301-443-7261

AOA RESPONSE: Yvonne Jackson, Director, OAIANNHP, (202) 619-2713

HCFA RESPONSE: Linda Brown (HCFA) Technical Director – (202) 690-8172

AHRQ RESPONSE: Wendy Perry, Senior Program Analyst 301-594-7248

CDC RESPONSE: Ralph T. Bryan, MD, Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, Office of the Director, CDC,505-248-4226
Dean S. Seneca, MPH, Minority Health AI/AN Program Specialist, Office of the Associate Director for Minority Health, Office of the Director, CDC,404-639-7210

HRSA RESPONSE : Karen Garthright, Public Health Analyst, Office of Minority Health, 301-443-9424.

IGA RESPONSE: Andrew D. Hyman Director, Office of Intergovernmental Affairs (202) 690-6060, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs,(202) 401-9964

SAMHSA RESPONSE: Steve Sawmelle Intergovernmental Coordinator , Office of Policy and Program Coordination, (301) 443-0419

ACF RESPONSE: Alexis Clark Budget Analyst, ACF Office of Legislation and Budget; (202) 401-4530

FDA RESPONSE: N/A

SECTION I: FUNDING/BUDGET ISSUES

#13		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
It is inappropriate to consider third party collections in funding considerations.		HCFA IHS

1. Public Law(s) or authorization related to this issue/issue area:

IHS RESPONSE: The Indian Health Care Improvement Act (Public Law 94-437, as amended) provides for how third-party collections should be treated. Title II, Sec. 207, (b) "Crediting of Reimbursements" states "The Service may not offset or limit the amount of funds obligated to any service unit or entity under contract with the service because of the receipt of reimbursements under subsection (a)". In addition, Section 401 (a) "Treatment of Payments Under Medicare Program" also provides that " Any payments received....shall not be considered in determining appropriations for health care and services to Indians." Then, under Section 402 "Treatment of Payments Under Medicaid Program" section (b) also provides that "Any payments received by such facility for services provided to Indians eligible for benefits under Title XIX of the Social Security Act shall not be considered in determining appropriations for the provision of health care and services to Indians."

HCFA RESPONSE: When Congress enacted the Indian Health Care Improvement Act, it included provisions in sections 401(d) and 402(b) that Medicare and Medicaid payments received by a facility of the Indian Health Service shall not be considered in determining appropriations [for IHS] for health care and services to Indians.

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:

IHS RESPONSE: The OPDIV/STAFFDIV should consider policy that will reflect these statutory requirements in the development of the annual budget for the IHS to clarify that the M/M and third party collections are not to be used in the calculation of the fiscal year budget for the IHS.

HCFA RESPONSE: HCFA has no role in setting the amount of IHS appropriations.

3. OPDIV/STAFFDIV activities to date on this issue/issue area:

IHS RESPONSE: None

HCFA RESPONSE: We are working on an ongoing basis with IHS and IHS-funded Tribes and urban Indian organizations to assure that Medicare and Medicaid payments to Indian providers are made appropriately.

4. Appropriations information related to the issue/issue area (FY00, FY01):

IHS RESPONSE: Nothing that specifically addresses this issue.

HCFA RESPONSE: IHS reports on estimated amounts of Medicare and Medicaid collections in their Congressional Justification document submitted to the Appropriations Committees each year.

5. Obstacles to addressing issue/issue area:

IHS RESPONSE: Despite the change from Federal deficits to Federal surpluses the budget caps established by the Balanced Budget Act of 1997 remain in affect through FY 2002. The FY 2001 budget allocation provided for the House Interior Appropriations Subcommittee was $302 million below the FY 2000 level and $1.7 billion less than the amount requested by the Administration. While the Senate Interior Subcommittee has received a budget allocation that is greater than the House's, it is still significantly below the President's request. The President has proposed discretionary spending limits at levels necessary to serve the American people, including American Indians/Alaska Natives. The Administration has consistently reminded Congress that the allocation to the Interior Subcommittees is insufficient to make the necessary investments in Indian programs.

HCFA RESPONSE: Executive Branch agencies cannot compel Congress to abide by the limitations in the IHCIA.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: The Indian Health Service needs to continue to present the health care needs of Indian people in such a way that our budget is a top priority whenever funding allocation decisions are made. This will include consulting with tribal representatives, and working with staff from HHS, OMB and the Appropriations Committees, to ensure that the information needed to make the most compelling possible case is presented in a timely manner.

HCFA RESPONSE: HHS agencies can continue to work together to maximize the total amount of funding received by IHS, Tribal, and urban Indian health programs from various budget sources, including efforts to assure that Administration budget proposals to the Congress for IHS are not reduced due to 3rd party resource collections.

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
IHS RESPONSE: Michael Mahsetky, Director of Legislative and Congressional Affairs, Office of the Director, Indian Health Service,301/443-7261

HCFA RESPONSE: Sue Clain (HCFA/OL) – (202) 690-8226

SECTION I: FUNDING/BUDGET ISSUES

#14		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Impact of managed care on tribes (e.g., decreased reimbursements) should be considered.		All OPDIVs/STAFFDIVs

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

ACF RESPONSE: There is no ACF program authority that provides funding for health services. (See issues # 1, 4, 8.) While HS provides for health care this is primarily for preventive and referral services

HCFA RESPONSE: N/A

AHRQ RESPONSE: N/A

CDC RESPONSE: Not Applicable to CDC as this Agency is not directly involved with the delivery or reimbursement of managed care.

HRSA RESPONSE: The Social Security Act requires cost-based reimbursement to tribal clinics and health centers. This should provide a cushion for those tribal clinics/centers in managed care. Tribes are exempt from the managed care provisions of the Balanced Budget Act of 1997.

IGA RESPONSE: N/A

SAMHSA RESPONSE: Under the Balanced Budget Amendment of 1997, states can generally require mandatory enrollment of Medicaid enrollees into state/public managed care programs without waivers. However, American Indians/Alaska Natives Medicaid enrollees are excepted from this requirement. States can only require AI/ANs in Medicaid to receive services under a managed care organization (MCO) if the MCO is IHS, a tribally operated program, or an urban Indian health program. States do have the ability to require mandatory enrollment of Native Americans in Medicaid managed care programs under HCFA's 1115 or 1915B waiver authorities if such inclusion is sought and approved.

FDA RESPONSE: N/A

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:

IHS RESPONSE: The HCFA is in the process of responding to a similar issue raised by tribal leaders at the HCFA tribal consultation meetings held last year. It is IHS' understanding that the HCFA supports the use of out-of network payment system for I/T/U providers and intends to send a formal State Medicaid Director's letter promoting an out-of-network reimbursement mechanism. States that have already incorporated out-of-network payments into their managed care programs, such as Arizona and Oklahoma, would be used as models.

ACF RESPONSE: Not Applicable

HCFA RESPONSE: The Center for Medicaid and State Operations with HCFA will be sending out letters to the Tribes and the States strongly encouraging them to work together on increasing ITU access to managed care contracts and mitigating any negative impact the implementation of Medicaid managed care may have.

AHRQ RESPONSE: : AHRQ does research on the organization of health care services including managed care issues. Some of this research may be relevant to tribes. To help tie together the results of AHRQ-supported research and tribal health care system needs, AHRQ is sponsoring a three day long User Liaison Program Workshop in June 2000 to specifically address issues of import to Indian health care systems upon which the results of AHRQ research can shed some light. Representatives from many tribes, American Indian and Alaska Native (AI/AN) health care organizations, and the Indian Health Service are taking part in and speaking at this workshop.

HRSA RESPONSE: N/A

IGA RESPONSE: Consistent with the Secretary's policy, IGA will assist States in the development and implementation of mechanisms for consultation with their respective tribal governments and Indian organizations before taking actions that affect these governments and/or the Indian people residing within their State. Assign the Inter-Agency Tribal Consultation Workgroup to address State and Tribal issues with tribal participation.

FDA RESPONSE: N/A

SAMHSA RESPONSE: The Roundtable made a number of core recommendations, one of which was that education be improved for AI/AN behavioral health leaders on managed care, especially on negotiating contracts. In response to this recommendation, SAMHSA's Managed Care Initiative is planning to support regional training of AI/AN providers. The trainers would be experts in AI/AN issues and managed care contract negotiations.

3. OPDIV/STAFFDIV activities to date on this issue/issue area:

IHS RESPONSE: The IHS staff has worked with HCFA staff in the past during the review and approval process of the 1115 waiver demonstration proposals. Several states, such as Arizona and Oklahoma with significant Indian populations, have proposed and the Department has approved, an out of network reimbursement payment methodology. The HCFA and IHS joint steering committee may address this policy issue should staff not be able to reach agreement.

ACF RESPONSE: Not Applicable

HCFA RESPONSE: See #2 above

AHRQ RESPONSE:
Planned User Liaison Program Workshop--June 2000 (see above).

HRSA RESPONSE: If data does not exist, then a study should be conducted to assess the impact of managed care on tribal health care facilities and the ability of the population to access services. This may be a fruitful partnership area between the Indian Health Service, HRSA, and HCFA.

IGA RESPONSE: N/A

SAMHSA RESPONSE: The SAMHSA Managed Care Initiative supported a project that convened an American Indian/Alaska Native Roundtable of leaders in May 1999 to discuss mental health and substance abuse needs of AI/ANs within managed care systems. Participants included tribal and urban health directors, tribal behavioral health clinicians, IHS, administrators, researchers and consultants, and heads of regional and tribal Indian behavioral health agencies. A report is currently in draft format. Many at the meeting argued that most state managed care programs are not focused on the unique needs and values/traditions of AI/AN populations. They identified several critical issues in managed care systems serving this population; for example:

- Availability and Access: Disenrollment by MCOs is a particular problem for AI/ANs, as cultural differences may be seen by providers as noncompliant behavior. Access and availability of providers, especially in rural areas, is crucial
- Credentialing: Managed care has traditionally selected state-licensed professionals for their provider networks. Yet for AI/ANs, traditional healers and persons in recovery are often important providers that need to be included in managed care provider networks.

FDA RESPONSE: N/A

4. Appropriations information related to the issue/issue area (FY00, FY01):
IHS RESPONSE: N/A

ACF RESPONSE: N/A

HCFA RESPONSE: N/A

AHRQ RESPONSE: FY00-$180,000

HRSA RESPONSE: N/A

IGA RESPONSE: N/A

SAMHSA RESPONSE: The Native American provider training project is estimated at $50,000 in FY01.

FDA RESPONSE: N/A

5. Obstacles to addressing issue/issue area:
IHS RESPONSE: Some States have been hesitant to adopt an out-of-network reimbursement system because they have already paid a managed care organization (MCO) a capitation payment to cover the cost of health care provided to Medicaid beneficiaries. Some States view an out-of-network payment to an I/T/U as a duplicate payment.

ACF RESPONSE: N/A

HCFA RESPONSE: States and Tribes may not be able to work together in the manner encouraged by HCFA. This may require additional technical assistance from HCFA.

AHRQ RESPONSE: AHRQ receives very few grant applications from tribal organizations/groups.

HRSA RESPONSE: HCFA has a person designated to address the issue. Any actions could be built around the assignee.

IGA RESPONSE: The lack of consideration, of AI/AN issues, is an obstacle in State managed care systems. Access and availability of providers is crucial especially in rural areas

SAMHSA RESPONSE: Lack of consideration of AI/AN issues as noted above in state managed care systems constitutes the major obstacle.

FDA RESPONSE: N/A

6. Strategies to overcome obstacles:
IHS RESPONSE: In those States that have adopted an out-of-network reimbursement mechanism, the States avoid duplicate payments by paying the I/T/U for the out-of-network services and then perform an end of year cost settlement with the MCO based on utilization. For Medicare, regulations are necessary to allow IHS and tribal hospitals to be reimbursed for Indian patients enrolled in HMS's.

ACF RESPONSE: N/A

HCFA RESPONSE: See #2 Above

AHRQ RESPONSE: AHRQ is undertaking efforts to apprise tribes of particularly pertinent "Requests for Applications" (i.e., calls for grant applications on specific topics), e.g., by sending all tribal leaders letters about such opportunities. Once its tribal consultation plan is approved, AHRQ plans to send information to each tribe about the agency and funding opportunities, including its ongoing "Program Announcement" which identifies ongoing areas of research interest for which grant applications are accepted.

HRSA RESPONSE: There is a body of literature about the impact of managed care on safety net providers, including the new Institute of Medicine study. However, it is our understanding that there are special arrangements for Indian Health Service beneficiaries and tribal clinics which were not addressed in this study and which need to be explored with the Indian Health Service.

IGA RESPONSE: Encourage States to consider American Indian/Alaska Native issues in State managed care systems and to work with Indian tribes and IHS, HCFA, HRSA and others to address this issue.

SAMHSA RESPONSE: Provider training to help AI/ANs become experts on managed care issues and contracting helps address this obstacle.

FDA RESPONSE: N/A

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
IHS RESPONSE: Elmer Brewster, Health Administrator, Office of Public Health, Indian Health Service, 301-443-1016

ACF RESPONSE: Tom Tregear, Chief, American Indian Program, Head Start Bureau (202) 205-8437

HCFA RESPONSE: Nancy Goetschius(HCFA) – (410) 786-0707

AHRQ RESPONSE: Wendy Perry, Senior Program Analyst 301-594-7248

HRSA RESPONSE: Alexander Ross, Senior Program Analyst, Center for Managed Care, 301-443-1550.

IGA RESPONSE: Andrew D. Hyman, Director, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, (202) 690-6060

SAMHSA RESPONSE;: Steve Sawmelle Intergovernmental Coordinator , Office of Policy and Program Coordination, (301) 443-0419

FDA RESPONSE: N/A

SECTION I: FUNDING/BUDGET ISSUES

#15		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Difficult to implement new approaches to care without adequate or accessible funding.	Provide more funds for demonstration grants on important health issues.	All OPDIVs/STAFFDIVs

1. **Public Law(s) or authorization related to this issue/issue area:**

IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

ACF RESPONSE: There is no ACF program authority that provides funding for health services. (See issues # 1, 4, 8.) Native American Programs Act of 1974, as amended is not authorized to provide health services. It does authorize funds for a wide range of innovative approaches and strategies addressing social development, economic development and governance development. ANA projects may also address important and emerging issues in Indian Country such as in the health field, as well as environmental and energy capacity building, to name a few examples.

AOA RESPONSE: Proposed reauthorization language adds the National Family Caregiver Support Program to OAA Title VI.

HCFA RESPONSE: None: (NOTE: See Also Response to Issue #35)

AHRQ RESPONSE: N/A

CDC RESPONSE: Not Applicable to CDC as this Agency does not provide direct health care services.

HRSA RESPONSE: (Rural Health Policy) Public Law: Section 330A of the Public Health Service Act as amended by the Health Care Consolidation Act of 1996, Public Law 104-299.

IGA RESPONSE: Ticket to Work & Work Incentive Act of 1999. Medicaid Infrastructure Grants $500,000/year. Community Access Program Grants

SAMHSA RESPONSE: 42 USC 290aa, 42 USC 290ff

FDA RESPONSE: Public Health Service Act, Chap. 288—37 Stat. 309 (1912), 42 U.S.C., subsection; 201 et. seq., Miscellaneous Provisions Relating to Orphan Drugs, Section 5, Orphan Drugs Act, P.L. 97-414; 21 U.S.C. 360ee, and P.L. 106-107 (Simplification of Federal grant programs for the benefit of recipients.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

IHS RESPONSE: IHS has proposed a variety of program investments to support demonstration activities for new interventions. Tribes have indicated a preference for formulary distribution of resources rather than grants for IHS funds during the budget formulation process.

ACF RESPONSE: : Tribes are eligible to apply under the basic SEDS (Social and Economic Development Strategies) program, the environmental enhancement program and the Native language program. Applications may be submitted to ANA addressing health issues especially in relation to ANA's governance goal, but not for health services funding. These type applications submitted under SEDS must compete with other SEDS applications.

AOA RESPONSE: Pending reauthorization of the OAA, AoA will develop guidelines for the Tribes to apply for the Family Caregiver demonstration projects.

HCFA RESPONSE: While there have been some discussions in the past with various tribes concerning possible Medicare and Medicaid demonstrations, no concrete proposals were developed that were consistent with HHS policy.

AHRQ RESPONSE: See #3 below. In addition, once AHRQ's tribal consultation plan is vetted with the tribes, the agency will send information to all tribal leaders familiarizing them with the agency and its work and explaining funding opportunities. When specific funding opportunities arise that are particularly relevant to tribes, the agency will not only send letters to each tribe about that opportunity, but try to get it included on pertinent web sites frequented by tribal officials, e.g., the IHS web site, the NIHB website, etc.

IGA RESPONSE: Community Access Program (CAP) staff preparing to identify non-federal tribal staff to review proposals. Recommend to all OPDIVs as a standard practice, to clearly indicate on their grant announcements that AI/ANs are eligible to apply.

SAMHSA RESPONSE: American Indian or Alaska Native grantees from Phase I of the Community Action Grant for Service Systems Change, will be eligible to apply for Phase II, Implementation Support, in FY 2001 or 2002. FAS/FAE Prevention within a four-state consortium (Montana, Minnesota, South Dakota and North Dakota): This 3-year cooperative agreement is designed to estimate the incidence and prevalence of Fetal Alcohol Syndrome (FAS) in North Dakota, South Dakota, Montana and Minnesota, as well as to implement and test prevention interventions. FAS/FAE Prevention and Treatment for the State of Alaska: This initiative will involve Native Alaskans and Tribal Councils, as representatives and active participants in a working group, advisory council, and data collection and treatment efforts. This is a comprehensive, integrated program designed to help eliminate FAS/FAE births in the State of Alaska, and to expand services to those individuals already affected by FAS/FAE within the State. SAMHSA's Office of Minority Health will continue to provide technical assistance to Tribal Colleges and Universities on developing high quality and competitive SAMHSA grant/contract applications.

FDA RESPONSE: FDA uses a variety procurement authority, interagency and cooperative agreements. As a rule, FDA announces competitive contracts and intramural and grants through the FDA home page and the Commerce Business Daily. FDA is working with the Office of Management and Budget to develop uniform administrative rules and common application and reporting systems; replace paper with electronic processing in administration of grant programs; and to identify statutory impediments to grants simplification.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

IHS RESPONSE: The IHS has awarded a variety of grants in FY 2000 to support demonstration activities. This includes programs in oral health, public health nursing, elder care, child abuse, mental health, and pharmacy activities.

ACF RESPONSE: : Submission of planning grants for health facilities and health capacity building, health business development and health education are examples of allowable applications under SEDS. ANA has funded several projects relating to important health issues. In the last few years the Laguna Pueblo was awarded a SEDS grant for planning for a long term care facility. The National Indian Health Board (NIHB) was awarded a SEDS grant to conduct a quantitative study on the impact of self-determination contracting and self-governance compacting activities nationwide, development of a strategic planning document and the implementation of a management information system. A current NIHB grant is to develop a health care curriculum and provide distance-base learning and to develop a strategy and facilitate tribal/state communications to enhance tribal health care programs/management capabilities.

AOA RESPONSE: AoA has been advocating for the National Family Caregiver Support Program.

HCFA RESPONSE: N/A

AHRQ RESPONSE: A few years ago, AHRQ sent letters to all tribal leaders to familiarize them with the agency and its work. AHRQ has written letters directly to tribal leaders over the last year or so to make them aware of pertinent "Requests for Proposals." AHRQ will continue to do this.

HRSA RESPONSE: The Office of Rural Health Policy administers the Rural Health Outreach Grant Program for which tribal organizations, among others, are eligible. The programs aim is to expand access to quality health care through coordination efforts at the local level. The emphasis is on service delivery through creative strategies requiring the grantee to form a network with at least two additional partners. Programs funded have varied greatly and have included consortia of schools, churches, emergency medical service providers, local universities, private practitioners and the like. Rural communities have managed to create hospice care, bring health check-ups to children and provide prenatal care to women in remote areas. To be eligible the grant recipient's headquarters must be a public or nonprofit private entity and be located in a designated rural county, or exclusively provide services to migrant and seasonal farm workers in rural areas, or be a Native American Tribal or quasi-tribal entity. Tribal organizations are eligible for grants under the Rural Health Outreach Grant Program. Tribal organizations interested in applying need not be located in a rural (non- MSA) county as long as the applicant is a tribal organization that is located on federally recognized tribal lands or a reservation, and the project proposed is health related.

IGA RESPONSE: IGA has provided a list of tribal reviewers for the CAP review. Senior Advisor Tribal Affairs reviewed grant announcement and recommended that their announcement clearly state that AI/AN tribes were eligible for these grants. As a result there were a number of tribes who submitted applications.

SAMHSA RESPONSE: In FY 2000, a Community Action Grant for Service Systems Change grant was issued with a priority initiative for American Indian Alaska Native Youth. This grant offering was part of an interagency effort to provide tribes with easy-to-access assistance in developing innovative strategies that focus on the mental health, behavioral, substance abuse, and community safety needs of American Indian young people and their families through a coordinated Federal process. The lead SAMHSA Center was CMHS, with participation from CSAP and CSAT. Federal partners in the initiative were the Indian Health Service and the Departments of Justice, Education, and the Interior. CSAT maintains responsibility for discretionary grants for substance abuse treatment through its Targeted Capacity Expansion (TCE) program, which tribes have accessed quite successfully, and will continue to contribute to Knowledge Development and Application grants to develop and replicate innovative approaches to providing substance abuse treatment, including to Indian populations.

FDA RESPONSE; : FDA posts opportunities on the FDA home page and provide links to the Department of Health and Human Services' GrantsNet home page, and CODETalk.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: In FY2000, approximately $5.5M was allocated to these grants and the amount in FY2001 will be the same.

ACF RESPONSE: FY 2000 ANA appropriations is $35 million dollars and $44 million dollars is proposed in the President's budget for FY 2001.

AOA RESPONSE: A set aside for funding Tribal Family Caregiver demonstration programs is included in the reauthorization language. Additionally, the Administration has included funding this program in FY 2001.

HCFA RESPONSE: Senate Appropriations Committee language encouraged HCFA support of a project with the Rocky Boy Tribe, but there was no mandate and we have not been contacted with a proposal.

AHRQ RESPONSE: N/A

HRSA RESPONSE: Appropriations:

	FY 2000	FY 2001
	$37,338,000	$38,892,000

IGA RESPONSE: N/A

SAMHSA RESPONSE: Community Action Grant for Service Systems Change - FY 2000 - $450,000 (representing $150,000 each from CMHS, CSAP, and CSAT)
CSAP's FAS/FAE four-state consortium - FY 2000 - FY 2003, $2.8 million
CSAP's FAS/FAE project for Alaska - FY 2000-2005 - $5.8 million

FDA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: The tribal programs have indicated a greater desire to have any IHS program increases provided under formulary methods rather than grants. Tribes cannot access HHS block grant funds targeted at States and tribes have had limited success in receiving competitive grants from other HHS agencies.

ACF RESPONSE: ANA's grant application review process is highly competitive and there is insufficient ANA funds to approve all meritorious applications.

AOA RESPONSE: Reauthorization of the Older Americans Act.

HCFA RESPONSE: N/A

AHRQ RESPONSE: : AHRQ is not very well known in Indian country and receives very few grant proposals from tribal groups.

HRSA RESPONSE: Since inception, the Outreach Grant Program has funded projects that serve Native Americans. In FY 1999, for example, approximately 20 percent of grantees are either tribal organizations, are members of the applicant's network, or provide services to Native Americans.

IGA RESPONSE: N/A

SAMHSA RESPONSE: Tribes often are not notified of the existence of discretionary grant opportunities. There is a limited research base for culturally specific and appropriate approaches.

FDA RESPONSE: N/A

6. **Strategies to overcome obstacles:**

IHS RESPONSE: The agency and tribes are working with other HHS elements to strengthen the ability of tribes to compete for discretionary grants. In addition, tribes and the agency are working with other agencies to assure that discretionary grant offerings are targeted at the elimination of the unique health disparities affecting American Indians and Alaska Natives. Tribal access to block grant funds will require legislative or regulatory changes to assure that those funds provided to States are available to Indian communities.

ACF RESPONSE: Not Applicable

AOA RESPONSE: Continue to work with Congress to reauthorize the OAA.

HCFA RESPONSE: N/A

AHRQ RESPONSE: A few years ago, AHRQ sent letters to all tribal leaders about the agency and its work; AHRQ will do this again once its tribal consultation plan is vetted with the tribes. AHRQ has been trying to "get the word out" on particularly pertinent funding opportunities by, for instance, writing to all tribal leaders about grant opportunities and apprising interested Native American groups such as NIHB and AAIP of grant opportunities. AHRQ will also try to get funding opportunities cited on websites frequented by tribal officials, e.g., the IHS website.

HRSA RESPONSE: Since inception, the Outreach Grant Program has funded projects that serve Native Americans. In FY 1999, for example, approximately 20 percent of grantees are either tribal organizations, are members of the applicant's network, or provide services to Native Americans.

IGA RESPONSE: N/A

SAMHSA RESPONSE: SAMHSA will continue to target mailings of grant announcements to tribes and Tribal Colleges and Universities and also periodically conduct grant application technical assistance seminars throughout the nation to assist in this effort. SAMHSA will continue to evaluate knowledge development and application programs to determine which models work best for what groups under what conditions, and work with the field to adopt new, more effective and culturally appropriate approaches to services.

FDA RESPONSE: : FDA invites ideas to make it easier for State, local, and tribal governments and nonprofit organizations to apply for and report on Federal grants.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: W. Craig Vanderwagen, M.D., Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service (301) 443-4644

ACF RESPONSE: : Sharon McCully, Executive Director, Intra-departmental Council on ,Native American Affairs/ANA (202) 690-5780

AOA RESPONSE: Yvonne Jackson, Director, OAIANNHP, (202) 619-2713

HCFA RESPONSE: Bill Saunders (HCFA/OSP) – (410)786-6533

AHRQ RESPONSE: Wendy Perry, Senior Program Analyst 301-594-7248

HRSA RESPONSE: Office of Rural Health Policy Contact: Eileen Holloran, Outreach Program Director, 301-443-0835

SAMHSA RESPONSE: Steve Sawmelle , Intergovernmental Coordinator , Office of Policy and Program Coordination, (301) 443-0419

FDA RESPONSE:

SECTION I: FUNDING/BUDGET ISSUES

#16		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Services provided to other tribes limits or reduces funds to tribes providing the service (open-door policy issue).		IHS , AOA

1. **Public Law(s) or authorization to this issue/issues area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis. On September 16, 1987 , after extensive consultation with tribes, and rejection of any blood quantum requirement, the IHS published regulations that would have limited eligibility to tribal members. However, Congress placed a moratorium on these regulations and required IHS to use the pre-1987 regulations to determine eligibility for services that do not place any limitation on Indian descent. Thus, the IHS operates under an open door policy, 42 CFR 36.12(a) (1986). This means IHS provides services to all persons of Indian descent belonging to the Indian community served. Under section 105(g) of the Indian Self-Determination and Education Assistance Act (ISDEA), P.L. 93-638, tribes contracting/compacting to operate health programs must adhere to the IHS eligibility regulations.

AOA RESPONSE: : N/A

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The proposed legislation to re-authorize the Indian Health Care Improvement Act (IHCIA), H.R. 3397 and S. 2526, contains a new provision, section 811. This provision authorizes the Secretary to end the moratorium on implementation of eligibility regulations if new criteria governing eligibility for health services are developed under enhanced Negotiated Rulemaking procedures in consultation with tribal governments.

AOA RESPONSE: Although additional Tribes may apply for Title VI and AoA may approve their applications, no funds are provided to new Title VI applications until there is an increase in appropriations.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: For the convenience of the public and to conform to the Administrative Procedures Act (APA) requirements, the IHS republished the effective regulations (pre-1987) at 64 FR 58318 (October 28,1999). On January 10, 2000, Dr. Trujillo sent a copy of the republished regulations in a letter to all tribal leaders reaffirming the IHS "open door" policy.

AOA RESPONSE: No new applications are funded unless Title VI appropriations are increased. AoA approved nine new applications in 1999 but have not funded them since Title VI received no additional funds in 1999 or 2000.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: Since FY 1988 and in each subsequent annual appropriation act, the Congress has restricted the use of appropriated funds for implementation of the September 16, 1987 regulations until the IHS submits a budget request reflecting increased costs associated with the regulations published in September 16, 1987. The IHS conducted a preliminary study in 1989 regarding costs associated with implementation of the 1987 regulations, but has not submitted a budget request pending further study as required by section 719(b) of the IHCIA, Pub. L. 100-713.

AOA RESPONSE: For FY 2001, AoA has requested an increase of 5 million dollars for the Title VI program. If these additional funds are received, the funding to current grantees will be increased and the nine new applications that have been approved will be funded. If the Title VI funding is not increased for FY 2001, the new applications will not be funded.

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: Due to the Congressional moratorium, the IHS is restricted from implementing the 1987 regulations that would restrict services to members of federally recognized tribes and is required to follow the pre-1987 regulations that place no restriction on Indian descent for determining eligibility for services. The IHS and tribes together are faced with the difficulty of continuing to provide heath care to Indian people as the Indian population continues to grow and the cost of health care continues to rise, while the appropriations do not keep pace with either.

AOA RESPONSE: Funding limitations.

6. **Strategies to overcome obstacles.**
IHS RESPONSE: Section 811 of H.R. 3397 and S.2526, legislation re-authorizing the IHCIA, would lift the moratorium imposed by Congress and authorize the IHS to begin the enhanced Negotiated Rule making process with tribes. This process would allow the IHS and tribes an opportunity to develop criteria for eligibility for health services provided by IHS and tribes.

AOA RESPONSE: Request increased funds.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number);**
IHS RESPONSE: Les Morris, Director, Division of Regulatory and Legal Affairs, Office of Management Support, Indian Health Service, 301-443-1116

AOA RESPONSE: Yvonne Jackson, Director, OAIANNHP, (202) 619-2713

SECTION I: FUNDING/BUDGET ISSUES

#17		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
	Assist tribe in working with HCFA in the area of "managed care."	HCFA

1. **Public Law(s) or authorization related to this issue/issue area:**

HCFA RESPONSE: Title XIX of the Social Security Act.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
HCFA RESPONSE: HCFA is developing a letter to the Tribal Directors and the State Medicaid Directors encouraging them to work together in the development of Medicaid managed care waiver proposals for Tribes in their States. HCFA also plans to

encourage States to accept some Federal standards, which ITUs must meet in lieu of equivalent State requirements for participation in managed care contracts which may be barriers to ITU participation.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
HCFA RESPONSE: The Center for Medicaid and State Operations within HCFA is preparing a letter to State Medicaid Directors and Tribal leaders on this issue. HCFA Regional Offices are also continuing to help ITUs further understand the managed care environment.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
HCFA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**
HCFA RESPONSE: Possible reluctance of States in responding to HCFA's "encouragement."

6. **Strategies to overcome obstacles:**
HCFA RESPONSE: We believe that any obstacles will be diminished by the above mentioned letter.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
HCFA RESPONSE: Nancy Geotschius (HCFA) -- 410-786-0707

SECTION I: FUNDING/BUDGET ISSUES

#18		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
	Support provision that authorizes IHS to enter into capitation agreements for managed care.	HCFA IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

HCFA RESPONSE: Medicare managed care operates primarily through the Medicare + choice program (sections 1851-1859 of the Social Security Act), plus some cost contracts with HMOs under section 1876 and some demonstrations under section 402(a) of the Social Security Amendments of 1967 and section 222 of the Social Security Amendments of 1972. Medicaid managed care operates under a Medicaid State Plan amendment under section 1932 of the Social Security Act or through waivers granted under sections 1115 or 1915(b) of the Act. States may use managed care approaches to deliver SCHIP services under Title XXI of the Social Security Act (or through waivers of Title XXI under section 1115 of that Act.)

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: IHS and HCFA are working on possible approaches both from a policy and legislative perspective to authorize the IHS to enter into capitation agreements for managed care.

HCFA RESPONSE: Based upon information and recommendations received during consultations and other contracts, we are considering a range of legislative, regulatory, policy, and technical assistance approaches to help Indian health care providers and beneficiaries make informed choices about the benefits and challenges or participation in managed care. HCFA staff will continue to facilitate sharing among States of best practices in managed care payment, use of non-risk or lower risk managed care approaches, and other strategies. There is an IHS project which would allow it to accept capitation payments and participate as a provider in the Arizona Medicaid managed care Section 1115 demonstration waiver.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The State of Arizona has submitted an amendment to their Medicaid 1115 demonstration waiver to allow capitated payments to the IHS Tuba City Service Area on the Navajo Reservation. An IHS, HCFA, State and Tribal workgroup has been established under the leadership of the Navajo Area Director to address the legal and policy issues. Section 412 of H.R. 3397 and S. 2526, legislation to reauthorize the IHCIA, provides specific legislative authority for the IHS Tuba City Service Unit to participate in a demonstration project with the State of Arizona to provide services to Medicaid eligibles and receive payment on a capitated basis.

HCFA RESPONSE: HCFA has been actively consulting with IHS, Tribes and Indian organizations on many Indian health managed care issues and strategies to address them. Some Medicaid State agencies have, in consultation with Tribes in their State, adopted innovative strategies for supplementing the usual managed care capitated payments to Indian providers. Other States use primary care case management (a non-risk based approach to managed care), other ways to reduce financial risk to Indian health providers within managed care systems, and/or payments to Indian health programs outside of managed care. HCFA staff has provided technical assistance to IHS regarding the implications of this project for Medicaid.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: NA

HCFA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: The Office of General Counsel has advised that the IHS is prohibited from entering into a capitated payment agreement for the provision of services if such an agreement would place the agency at risk in violating the Anti-Deficiency Act.

HCFA RESPONSE: IHS may be limited in its ability to participate in fully capitated manage care arrangements without additional assistance or new statutory waivers of the Anti-Deficiency Act. Tribal and urban Indian health programs do not have this legal limitation, although many lack the financial resources to make the financial risks of capitated managed care a prudent business decision.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: The IHS supports the provision in the reauthorization legislation, section 412, authorizing the Tuba City Service Unit demonstration project to enable the agency an opportunity to test out whether a capitated payment agreement is a feasible approach.

HCFA RESPONSE: New statutory authority and funding for stop-loss coverage, as well as managed care demonstration for one or more IHS service units in Arizona have been proposed by Tribes in the Indian Health Care Improvement Act re-authorization. The Tribal bill also contains a number of proposed exemptions from managed care requirements and proposed new requirements for payments to Indian health programs that may or may not be effective in addressing the identified problems.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: Elmer Brewster, Health Administrator, Office of Public Health, Indian Health Service, 301-443-1016

HCFA RESPONSE: Nancy Geotschius (HCFA) – (410) 786-0707, Sue Clain (HCFA/OL) – (202) 690-8226

SECTION I: FUNDING/BUDGET ISSUES

#19		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
	Facilitate free-standing health centers to bill Medicare for outpatient services.	HCFA IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

HCFA RESPONSE: IHS facilities are only permitted to bill Medicare for hospital and skilled nursing facility services under section 1880 of the Social Security Act. Clinics associated with hospitals can bill as outpatient departments of the hospital, but free-standing IHS clinics cannot bill Medicare under current law. (Note: This restriction does not apply to tribal or urban Indian programs operating out of their own clinics; nor does it apply to any Indian health program billing Medicaid or SCHIP.)

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The IHS has proposed legislative changes to Title 18 of the Social Security Act via the Department's A-19 legislative process and through the reauthorization of the IHCIA legislation.

HCFA RESPONSE: A legislative change would be necessary. HCFA will continue working with IHS to examine possible remedies, such as allowing IHS clinics to bill under the Medicare physician fee schedule or as if they were FQHCs or other approaches.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The Department has approved legislative initiatives to allow IHS freestanding clinics to bill for Medicare Part B services but such legislation has not been enacted.

HCFA RESPONSE: HCFA and IHS have worked together to examine the costs and benefits of various approaches to address this problem.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: By authorizing IHS freestanding clinics to bill Medicare the amount would be approximately a $4 million increase in Medicare expenditures.

HCFA RESPONSE: Preliminary estimates of options considered to date indicate a solution may result in about an additional $10-20 million per year being paid from Medicare to IHS clinics.

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: Despite the change from Federal deficits to Federal surpluses the budget caps established by the Balanced Budget Act of 1997 remain in affect through FY 2002. The FY 2001 budget allocation provided for the House Interior Appropriations Subcommittee was $302 million below the FY 2000 level and $1.7 billion less than the amount requested by the Administration. While the Senate Interior Subcommittee has received a budget allocation that is greater than the House's, it is still significantly below the President's request. The President has proposed discretionary spending limits at levels necessary to serve the American people, including American Indians/Alaska Natives. The Administration has consistently reminded Congress that the allocation to the Interior Subcommittees is insufficient to make the necessary investments in Indian programs.

HCFA RESPONSE: Legislation would be required, together with additional revenues or off-setting cost reductions to pay for the cost of the additional Medicare outlays.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: Increase efforts to expand these authorities to improve access to health care for AI/AN. HCFA and IHS have proposed that payments to freestanding clinic services be added to the Medicare Payment Demonstration project under section 402, the Secretary's authority to conduct such demonstrations.

HCFA RESPONSE: Sources of revenue or offsets should be identified.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: Elmer Brewster, Health Administrator, Office of Public Health, Indian Health Service, (301) 443-1016

HCFA RESPONSE: Sue Clain (HCFA/OL) – (202) 690-8226

SECTION I: FUNDING/BUDGET ISSUES

#20		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Change the allocation methodology for diabetes funding.		IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The agency establishes its allocation policies for diabetes funding in consultation with tribal leadership. All past allocations have been made with tribal guidance. This practice will continue. The principles for allocation are revisited annually with tribal leadership.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The agency meets with the Tribal Diabetes Advisory Committee generally on a quarterly basis to review progress made in implementing the diabetes grants, budgetary considerations, allocation concerns, and review of data needs. These meetings provide a clear opportunity for tribal leadership and the agency to assess outcomes and to revise policy or practices in a timely and appropriate manner.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: During FY2000, $33M was appropriated to this activity. In FY2001 the amount will be the same. These funds were provided for a 5-year period and will be available through FY 2003.

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: Despite the change from Federal deficits to Federal surpluses the budget caps established by the Balanced Budget Act of 1997 remain in affect through FY 2002. The FY 2001 budget allocation provided for the House Interior Appropriations Subcommittee was $302 million below the FY 2000 level and $1.7 billion less than the amount requested by the Administration. While the Senate Interior Subcommittee has received a budget allocation that is greater than the House's, it is still significantly below the President's request. The President has proposed discretionary spending limits at levels necessary to serve the American people, including American Indians/Alaska Natives. The Administration has consistently reminded Congress that the allocation to the Interior Subcommittees is insufficient to make the necessary investments in Indian programs.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: The Indian Health Service needs to continue to present the health care needs of Indian people in such a way that our budget is a top priority whenever funding allocation decisions are made. This will include consulting with tribal representatives, and working with staff from HHS, OMB and the Appropriations Committees, to ensure that the information needed to make the most compelling possible case is presented in a timely manner.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: W. Craig Vanderwagen, M.D., Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service, (301) 443-4644

SECTION I: FUNDING/BUDGET ISSUES

Issue # 21		
Issue	Recommendation	OPDIV Assignment
Definition of "Encounter"		
Repeated concerns about the lack of a consistent definition for an "encounter" by HCFA. This needs to be resolved in consultation with tribes. The current "rural rate" is too low. There needs to be an all-inclusive rate for dual-eligible patients.		IHS HCFA

1. Public Law(s) or authorization related to this issue/issue area:

IHS Response: Section 1911 of the Social Security Act provides authority for the IHS facilities to collect Medicaid reimbursements. Under a HCFA/IHS MOA, tribal programs have the option to convert to an "IHS provider" type and receive Medicaid reimbursements at the all-inclusive rate published annually in the Federal Register. This reimbursement methodology is also called the "encounter rate" because the IHS and tribal facilities are paid at a flat rate for Medicaid covered services provided during a 24 hour visit or encounter.

HCFA Response: HCFA - Section 1911 of the Social Security Act provides that an IHS-owned or leased facility, whether operated by the IHS or a Tribe or Tribal organization, shall be eligible for reimbursement for Medicaid services provided under a state plan so long as it meets all the conditions and requirements generally applicable to such facilities under the Medicaid statute.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

IHS Response: The IHS and HCFA have established a workgroup consisting of tribal representatives who are providing input into the development of a policy memorandum as to application of the all-inclusive rate that will include a definition of an encounter and what Medicaid covered services are covered by the all-inclusive rate. This policy memorandum will be applied nationally to all State Medicaid programs in which IHS and tribal programs operate. This policy memorandum will mean that tribal programs will be paid at the all-inclusive rate for Medicaid covered services provided in their facilities. Although the IHS rate is a facility cost based rate, the issue of the dual-eligible requires further analysis and may have to be addressed separately.

HCFA Response: HCFA - Issue Dear State Medicaid and Dear Tribal leaders letter clarifying what is an encounter.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

IHS Response: The IHS and HCFA held a meeting with tribal representatives on August 31, 2000 to discuss a draft options policy memorandum. The HCFA staff has met with the State Medicaid Directors on this issue as well. Follow up meetings are scheduled and perhaps a meeting will be held with IHS, HCFA, Tribal and State representatives to discuss and develop the policy memorandum further.

HCFA Response: HCFA and IHS staff have met to discuss the two issues regarding the all-inclusive rate: What should be covered by this rate and how should an encounter be defined. On August 30, 2000 IHS and HCFA staff met with Tribes to discuss these issues and receive input regarding their recommendations.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

IHS Response: N/A

HCFA Response: N/A

5. **Obstacles to addressing issue/issue area:**

IHS Response: One of the main obstacles in developing a national policy describing the application of the all-inclusive rate is the conflicting interest of the various entities and reaching a consensus as to a national definition. States have latitude and flexibility in the operations of the State Medicaid programs and might not want to agree to a national policy that might interfere with the operation of their programs. Some tribes and States have worked hard to negotiate a definition for their particular State program and a change in the definition could have an impact on the operation and level of Medicaid revenues of a tribal program.

HCFA Response: States and Tribes have varying views as to what should be covered by the encounter rate.

6. **Strategies to overcome obstacles:**

IHS Response: The legislation reauthorizing the Indian Health Care Improvement Act contains a provision to establish a qualified Indian health program (QIHP) that would establish a national reimbursement methodology for IHS, tribal, and urban programs on a full cost reimbursable basis. . The Department has not taken a final position on QUIP but will continue to work with the Congress to further the goal of this important legislation. In the mean time, the IHS and HCFA will continue to work with tribes and States in the development of a national definition that takes into the concerns and interests of the federal agencies, tribal programs, and State programs.

HCFA Response: IHS and HCFA have met with Tribes and National Association of State Medicaid Directors' Tribal Workgroup to discuss and decide how the all-inclusive rate should be applied and how to define encounter for the purpose of this rate. Based on these consultations, HCFA will prepare a dear Tribal Leader/State Medicaid Director letter to clarify the application of this rate.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

IHS Response: Kitty Marx, Senior Policy Analyst, Office of Management Support, Indian Health Service, (301) 443-6306; and Elmer Brewster, Senior Health Specialist, Office of Public Health, (301) 443-2419

HCFA Response: Christine Hinds, Health Insurance Specialist (410)786-4578, Larry Reed (410)786-3325SECTION I: FUNDING/BUDGET ISSUES

Issue #22		
Issue/Issue Area	**Tribal Recommendation**	**OPID/STAFFDIV Assigned**
HCFA/IHS Demonstration Project must include tribal 638 contractors. The proposed demonstration project being planned between HCFA and the IHS to eliminate IHS facilities from cost reporting requirements should also include tribal 638 contractors. Not all tribal contractors are FQHC and could benefit from this coverage		IHS HCFA

1. **Public Law(s) or authorization related to this issue/issue area:**

IHS Response: Section 1880 of SSA provides authority for IHS to collect Medicare. Section 402 provides the authority for the Secretary to conduct the Demonstration.

HCFA Response: The legal authority for this proposed demonstration resides in section 402 of the Social Security Amendments of 1967.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

IHS Response: The statement of the issue above is misleading in that Medicare cost reports will continue to be a requirement of all IHS and Tribal Hospital facilities for rate setting for Medicaid and to make sure that IHS is receiving reasonable reimbursements from Medicare. Over the next 5 years IHS is planning to do cost reports at all facilities. Tribal freestanding

outpatient clinics are not part of the Demonstration as planned; these clinics can bill Medicare as a FQHC or under the Physician provider number. The status of tribal participation will be further defined through the consultation process.

HCFA Response: Tribal consultation on the demonstration project started in late September and is on going. This, and other tribal concerns noted below, will be addressed during tribal consultation. The Steering Committee has a self-imposed of deadline of October 30 to submit a final proposal to HCFA.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

IHS Response: Currently a draft proposal is being finalized through joint working committees of IHS, HCFA and Tribes. Tribes are working with both Agencies in the development of the final product and will be involved in all aspects of the final approval process.

HCFA Response: See item 2

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

IHS Response: N/A---IHS third-party revenue is not part of the appropriations process and is not used in determining appropriated budget. The Demonstration will change how the IHS is reimbursed Medicare payments from fee for service to a per capita amount.

HCFA Response: There are no appropriations for this project. As with all demonstrations, this project must be approved by OMB.

5. **Obstacles to addressing issue/issue area:**

IHS Response: The Demonstration focuses on increasing access to, as well as achieving a more economical and effective utilization of services at, IHS owned or leased facilities, including 638 facilities owned or leased by IHS. The way in which other 638 facilities receive Medicare is different enough that it is very difficult to address their difficulties in the same Demonstration.

HCFA Response: There are still a number of issues to be addressed before a final proposal can be drafted. These include: the definition of each element of the calculation of the basic payment amount; the data to be used in the projections; the handling of payments for the dually eligible; the method of payment to the facilities; the right to continue to refer patients; the right to choose whether or not to participate in the demonstration; and the assurance that no facility will lose under the demonstration. Additional issues may arise during further consultations. The final package must still be approved within the Department and by OMB.

6. **Strategies to overcome obstacles:**

IHS Response: IHS needs to look at the difficulties that 638 facilities which are owned or leased by Tribes have in accessing Medicare and work with HCFA to see how these difficulties can be addressed.

HCFA Response: Through Tribal consultations, all of the issues will be addressed.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

IHS Response: Dr. John Yao, Office of Managed Care, Indian Health Service, (301) 443-2522, Fax (301) 443-9646; and Duane Jeanotte, Deputy Director of Health Policy, Office of Public Health, Indian Health Service, (301) 443-1083; and Elmer Brewster. Third Party Administrator, Office of Public Health, Indian Health Service, (301) 443-2419

HCFA Response: Ann Pash (HCFA) 410 786-4516

SECTION I: FUNDING/BUDGET

Issue #23		
Issue/Issue Area	Tribal Recommendation	OPDIV/STAFFDIV Assigned
CDC Funding: What percentage of the total CDC budget does the current tribal funding of $21 million represent? Tribal infrastructure for public health oversight is needed and should be supported through CDC funding. There was a specific inquiry regarding the recent decision by CDC to cut 50% of its support for Native American HIV/AIDS for capacity building in Indian communities. These funds should be restored, particularly in light of the limited disease surveillance in Indian country now.		CDC

1. Public Law(s) or authorization related to this issue/issue area:

CDC Response: N/A

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

CDC Response:

(1) Increased funding for AI/AN-specific programs and public health infrastructure support is a key component of CDC's FY 2002 budget request.

(2) CDC is aware that within Indian Country that AIDS prevalence does not adequately capture the full scope of the AIDS epidemic. CDC also agrees that more representative data are required to build a more accurate picture of the epidemic among American Indians and, as a result, to secure increased programmatic resources. CDC's National Center for HIV, STD, and TB Prevention has taken the following actions to address surveillance issues relative to American Indians:

(a) Encouraging states and local areas to collect more data that use self-report of race/ethnicity, such as the Supplement to HIV/AIDS Surveillance (SHAS) project in infected populations and the HIV Testing Survey (HITS) in at-risk populations. SHAS data can be used to evaluate race/ethnicity in the HIV/AIDS Reporting System and update misclassify records.

(b) Encouraging states to develop more collaborative disease reporting relationships with agencies serving American Indian population.

(c) Assigning Senior Epidemiologist to Indian Health Service National Epidemiology Program in Albuquerque who will assist in the coordination of national surveillance, prevention, and control activities for HIV/AIDS and related infections. Three primary activities are assisting Indian Health Service in development of a surveillance advisory council, conducting a system analysis of the current process used to report cases of HIV/AIDS and related infections among AIs/ANs, and conducting an assessment of risk factors for HIV/AIDS and opportunistic infections.

(d) Encouraging national AI/AN organizations to work collaboratively with the community in supporting surveillance data in HIV prevention community planning, the need for case finding, and disease reporting.

(e) Making changes in the presentation of slides and tables/charts in the Morbidity and Mortality Weekly Report that separates statistics of AI/AN populations.

(f) Encouraging more accurate reporting of race/ethnicity data by both providers and patients.

(g) Cooperatively with the U.S. Conference of Mayors (USCM), since 1985, to provide funding for the development of locally based HIV/AIDS prevention projects. In 1999, USCM provided HIV/AIDS prevention grants to three American Indian organizations.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

CDC Response: The percentage of the total CDC budget that the current tribal funding of $21 million represents is eight tenths of one percent for FY 1999. The total dollar amount for HIV capacity building awards from CDC's recent Program Announcement 00003, Capacity-Building Assistance to Improve the Delivery and Effectiveness of HIV Prevention Services for Racial/Ethnic Minority Populations, was lower than the amount provided by its predecessor program (Program Announcement 305). Both Program Announcement 0003 and its predecessor program provided funds for capacity-building activities to national

and regional minority organizations. It was not CDC's intention or a pre-determination of CDC to reduce funding to American Indian organizations in the area of capacity building assistance. Instead, award decisions for Program Announcement 00003 were made according to AID disease prevalence borne by racial/ethnic groups across the country, as well as scores of the applications as determined by an external review process. Use of the criteria of disease prevalence represented a change from the criteria of Program Announcement 305; this change was made because of several factors, including a series of consultations with HIV prevention partners, discussions with Congressional Black Caucus members about Congressional intent in funding allocations, analyses of the experiences and success of the HIV prevention community planning process, and CDC's other experiences in funding HIV prevention programs. The overall design of Program Announcement 00003 is to build capacity in communities hardest hit by the epidemic, thus CDC has strategically focused where the AIDS epidemic is most severe.

In FY 2000, under the umbrella of integrated capacity building assistance, the CDC provided funding to support local, regional, and national minority organizations to develop and deliver capacity building assistance to community based organizations and community stakeholders in four separate program announcements. While the overall direct funding to American Indian organizations was reduced in Program Announcement 00003, we believe there has been no actual reduction in these services to the American Indian community. Under 00003, American Indian organizations received direct funding in three priority content areas: enhancing intervention design, development, implementation, and evaluation; mobilizing community capacity building; and strengthening community planning effectiveness and participation. Also since the time of the 00003 funding decision, CDC, through the National Center for Chronic Disease Prevention and Health Promotion, awarded additional funds, approximately $50,000 to the National Native American AIDS Prevention Center for HIV prevention technical capacity building assistance for enhancing the intervention design, development, implementation, and evaluation for American Indian youth on reservations. Under Program Announcement 99091, one American Indian organization received funding for capacity building assistance to Organizations Serving Gay Men of Color.

4. Appropriations information related to the issue/issue area (FY00, FY01):

CDC Response: N/A; see Issue #4, Funding/Budget Issues

5. Obstacles to addressing issue/issue area:

a) Underreporting of HIV and AIDS cases in the American Indian community by both health care providers and individuals.
b) Cultural stigma related to HIV/AIDS.
c) Lack of public health infrastructure hinders disease reporting by the tribes.

6. Strategies to overcome obstacles:

CDC Response: See #2 and #3 above.

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
CDC Response: Ralph T. Bryan, M.D., Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention, c/o IHS Epi Program, 5300 Homestead Rd. NE, Albuquerque, NM 87110, Tel: 505-248-4226, FAX: 505/ 248-4393, e-mail: rrb2@cdc.gov; and Staff Liaison: Dean Seneca, Minority Health Specialist, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention MS-D39, 1600 Clifton Rd. NE, Atlanta, GA 30333, Tel: 404-639-7220, FAX: 404-639-7039, e mail: zkg8@cdc.gov

SECTION I. FUNDING/BUDGET

Issue # 24		
Issue/Issue Area	**Tribal Recommendation**	**OPDIV/STAFF DIV**
Increased Access to HHS Funding:	Set aside – Establish a set-aside of at least 1.5% of HHS budget for Indians. Current Levels – What is the exact percentage of each agency's budget now going to Indians? Legislative Changes -- Identify specific legislative changes needed to eliminate barriers preventing Indian populations from accessing HHS categorical and formula funded programs. Direct Funding of Tribes – Tribes should receive funding directly from the federal government and not be forced to go through the states to access federal health and human service resources, such as services for Severely Mentally Ill (SMI) populations and other HCFA resources.	All OPDIV's

1. **Public Law(s) or authorization related to this issue/issue area:**

ACF RESPONSE: Social Security Act, Title IV-E. ACF currently has direct funding to Tribes for Head Start, Child Care Development Funds program, Low Income Home Energy Program, Community Services Block Grant and the Native American Programs, to name a few. (See ACF program authorities chart at the end of this matrix) ACF is also supportive of direct funding to Tribes for Title IV-B and Title IV-E.

AHRQ Response: N/A

AOA Response: Older Americans Act (OAA) – Titles VI and IV

IHS Response:

Set aside - Establish a set-aside of at least 1.5% of HHS budget for Indians.

100% of IHS funding is set-aside to support programs for American Indians and Alaska Natives. These programs include health services and funding for facilities, through which health services are provided.

FY 00 appropriation: $2,390,728,000 plus $30,000,000 transferred to the IHS for diabetes through the Balanced Budget Act of 1997. IHS also estimates that $432,300,000 in Medicare, Medicaid, and Private Health Insurance collections will be provided to IHS and tribally operated health facilities for the provision of health care to Indian people.

FY 01 appropriation: $2,604,562,000 plus $30,000,000 transferred to the IHS for diabetes. IHS also estimates that $454,288,000 in Medicare, Medicaid, and Private Health Insurance collections will be provided to IHS and tribally operated health facilities for the provision of health care to Indian people.

ASMB Response: HHS administers a number of distinct programs to improve the health status and welfare of all Americans, including Indian people. The authorizing statutes for some HHS programs, such as the Indian Health Service (IHS) and the Administration for Native Americans (ANA) reserve program funds exclusively for Indian people. Other programs, such as Head Start and the Child Care Block Grant, have authorizing statutes which set-aside some program funds for Indian people. However, the authorizing statutes of most HHS programs, do not include set-asides for Indian people. Where such set-asides do not exist in law, HHS is generally prohibited from creating them administratively.

CDC Response: Listed below are the references to American Indians/Alaska Natives that appear in the FY 2001 Appropriation Language; no funding amounts are mentioned.

Native Populations

The Committee is concerned regarding the lack of adequate surveillance of HIV/STD among American Indian, Alaska Native, and native Hawaiian populations, and encourages CDC to work in consultation with tribes, urban programs, and the Indian

Health Service to develop a more effective surveillance strategy. Senate Language, Page 111 Violence prevention disparities in racial and ethnic populations. There are significant disparities in the numbers of racial and ethnic minorities affected by violence. The Committee is pleased with the efforts of CDC in the field of violence prevention. The Committee encourages CDC to extend the development and implementation of Best Practices for the Prevention of Youth Violence to include culturally sensitive social cognitive, mentoring, parenting, and nurse home visit programs and to identify new Best Practices. CDC should also develop and evaluate effective violence prevention programs that are designed to improve acceptability of violence prevention interventions in the communities they are intended to reach including African American, Hispanic American, American Indians and Alaska Natives, and Pacific Islanders. Culturally responsive interventions and programs should be developed through evaluation research and demonstrations to address the disparities in morbidity among racial and ethnic minorities that is attributable to violence. House Language, Page 52, 53

Suicide prevention
The Committee encourages CDC to establish a national suicide prevention resource center. This center would provide technical assistance to states and communities to identify and implement effective programs for those at significant risk for suicide, including African American males, American Indians/Alaska Natives, young adolescents, and the elderly. Senate Language, Page 107

FDA Response: FDA does not formulate its budget by population or ethnic group. FDA resources are organized into six programs that coincide with the organization of the President's annual budget. These programs are foods, human drugs, biologicals, medical devices and radiological health, animal drugs and feeds, and the National Center for Toxicological Research. FDA does not track or delineate the review of regulated products by population or ethnic group. The approval and/or review of any product is examined as a whole and not on a population basis.

HCFA Response: Medicare and Medicaid are individual entitlement insurance programs, where health care providers (including IHS, Tribal, and urban Indian health programs) that meet the conditions of participation and other requirements can bill for covered services provided to individuals enrolled in these programs. A set-aside percentage of funds for Indians would not fit into this structure and may even result in fewer funds being available than under current law if the percentage were set at or near the percentage of AI/ANs in the population, without adjustments for higher health risks and costs.

The SCHIP program also provides health insurance, but is a block grant entitlement to States and Territories. The Territorial portion is funded with a 1.05 % set-aside, which the Territories believe is too low (their population is 1.5% and poverty and health costs are high). Current SCHIP law allows Indian health providers to bill for covered services provided to individuals enrolled in the program. It does not contain an option for Tribes to operate the program (as they can for the TANF block grant), although Tribes have proposed such an option in their recommendations for re-authorization of the Indian Health Care Improvement Act.

IGA Response: N/A

NIH Response: P.L. 106-525, the Minority Health and Health Disparities Research and Education Act of 2000, directed the establishment of the National Center on Minority Health and Health Disparities (NCMHD) at the National Institutes of Health (NIH) and abolished the Office of Research on Minority Health (ORMH) within the Office of the Director. The Center will assist in the development of an integrated health research agenda aimed at addressing the current and emerging health needs of racial and ethnic minorities and other populations with health disparities. The Center will also support research training and other programs, including the dissemination of information with respect to minority health conditions and the disparate health status of other groups. The overarching goal is to promote and facilitate the creation of a robust environment for minority health disparities research and other health disparities research with sustained funding for a wide range of studies—basic, clinical, and behavioral research; studies investigating the influences of the processes by which health is maintained or improved; and research on the societal, cultural, and environmental dimensions of health—all aimed at identifying potential risk factors associated with disparate health outcomes. Because of the specific mission of the Center, its budget represents one pool of NIH funds to which Native Americans and other ethnic and racial minority groups would have improved access. Direct NIH funding support to Native Americans in FY 2000 totaled $839,253. Two grant awards were made to Dine College for an MBRS-SCORE Program and for Research Enhancement. One grant award was made to Fort Peck Community College for the Montana Consortium Bridges Program. Overall NIH support in FY 1999 for Native American related health research at various research institutions totaled $82.2 million. [Funding data sources include: the IMPAC system (direct

funding), the FY 99 Annual Report for the White House (eliminating health disparities), and the NIH Office of Budget (overall NIH funding for Native American related health research).

SAMHSA Response: 42 USC 300x ; and 42 USC 290ff

3. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

ACF RESPONSE: ACF recognizes the importance of providing quality services to Indian children who are in foster care under the custody of tribal courts. We believe it is important to ensure that Indian children in tribal foster care receive services that ensure their safety, permanency and well-being and that they receive the protections afforded to all other children in foster care. For this reason, our FY 2001 budget requests funds for HHS to conduct a comprehensive assessment of Indian child welfare programs, focusing on their strengths and the challenges they face in providing the kinds of services, protections and procedural requirements associated with the Federal foster care program. In addition, we propose to make grants to a limited number of tribes to enable them to strengthen the capacity of their tribal child welfare programs by addressing issues such as staff training and retention, licensing of foster care homes, conducting criminal background checks of prospective foster and adoptive parents, operating case review systems, and developing automated data collection systems. We believe that these efforts will enable us to develop improved technical assistance to tribes, better assess future policy directions, and develop models for strengthening tribal child welfare programs on a larger scale.

AHRQ Response: AHRQ is seeking to become better known among Indian populations so that more tribes and Indians will become familiar with and interested in the Agency's work and, as a result, seek to participate in Agency activities, e.g., health services research training programs, grant funding programs, etc.

AOA Response: The Administration on Aging (AoA) sets aside 1.9% of its total budget for Indians.

ASMB Response: ASMB will continue to co-host annual budget meetings which bring tribal representatives together with HHS policy officials. As these meetings continue, we believe they will lead to a better identification of specific HHS programs which could play a more critical role in improving the health and welfare of Indian people, to discussion of the barriers which may be keeping Indian people from accessing these programs, and to consideration of strategies for removing such barriers. ASMB is also working with IHS and the Health Care Financing Administration (HCFA) to develop an IHS Medicare Demonstration project which would expand the number of Medicare-covered services (e.g., to include physician services, etc.) For which IHS facilities could be paid. The first formal tribal consultation on the proposed project was held in late September.

CDC Response: Increased funding for AI/AN-specific programs and public health infrastructure support is a key component of CDC's FY 2002 budget request.

FDA Response: N/A

HCFA Response: HCFA plans to continue consultation with Tribes and others interested in Indian health matters and to use recommendations received to develop more effective legislative, regulatory, policy, and operational proposals to expand Indian access to enrollment and billing in HCFA programs. In addition, we will continue to work with the Tribal Steering Committee for the re-authorization of the Indian Health Care Improvement Act which has identified a number of barriers to Indian participation in HCFA programs and proposed many far-reaching changes to address them. HCFA and the rest of HHS will continue to analyze these proposals to identify approaches to best meet the most pressing needs.

IGA Response: HHS will work with tribes to identify barriers to Indian populations from accessing HHS-funded programs. We will also identify any legislative and/or administrative actions needed to eliminate those barriers. IGA is eager to work with tribal governments and states on this issue by convening a meeting in partnership with NCAI, the National Governors' Association (NGA), and other appropriate tribal and state government organizations to determine how best to ensure that tribes have fair access to HHS dollars.

NIH Response: In regard to access to NIH funds by minority serving institutions and/or faculty employed at these institutions, the NIH has developed a number of programs such as the Minority Biomedical Research Support (MBRS) Program and the Bridges Program to which Tribal Colleges and Universities (TCUs) might apply for funding. The MBRS program provides

research opportunities for faculty and students at TCUs. The Bridges program enables partnering between 2-year and 4-year institutions for the purpose of assisting students to make the transition for the purpose of earning the baccalaureate degree in the life sciences and related areas. The 4-year-Ph.D. Bridge assists students in gaining entry into Ph.D. programs. It is anticipated that the individuals who take advantage of these programs will be able to better compete for NIH funding.

Access to NIH funds is based on a competitive process, however, the pending legislation that is referenced in item 1 above should be sufficient to ensure better access by Native Americans to NIH funds. With the establishment of the Center, the goal is to create a more level "playing field" on which Native Americans could compete for health research funds. The concept of a level playing field is based on the premise that institutions with similar resources and capabilities should compete against each other for funding support from programs specifically designed with the strengths of those institutions in mind. Recognizing that participation at all levels is necessary in reducing and eliminating health disparities, the NIH is committed to designing programs that will provide opportunities for TCU-community partnerships to become engaged in implementing preventive strategies and in the translation of new knowledge from the bench to the bedside. Direct tribal funding is not a part of the NIH strategy. Obtaining grant awards depend on a competitive process that focuses on individual performance within the context of an energizing and supportive environment for the scientific enterprise. As such, the merit of a proposal is judged based on the credentials of the leadership of the project, productivity history, scientific environment, etc. The NIH can improve access to funds by designing effective programs aimed at increasing the number of Native American health scientists and by improving the research environment at TCUs through the development of programs that address research infrastructure issues.

SAMHSA Response: As described below, substantial funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) is provided to American Indian/Alaska Native (AI/AN) populations. While a 1.5% tribal set-aside is recommended in this matrix item, more than that amount is provided from SAMHSA's funding.

At the same time, however, neither of SAMHSA's block grant programs--the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services Block Grant--require expenditures by States for any specific racial/ethnic minority population. There is one exception in that SAPT Block Grant funds are currently provided directly to one tribe--the Red Lake Band of Chippewa Indians in Minnesota.
Given the continuing unmet needs of AI/AN populations, as demonstrated clearly by SAMHSA's most recent National Household Survey, HHS will undertake internal discussions to assess the current funding structure of block grants. (This pertains to other Operating Divisions of the Department as well.) The intention of these discussions is to develop options for the enhancement of funding services to these populations.

4. OPDIV/STAFFDIV activities to date on this issue/issue area:
ACF RESPONSE: Working with Congress to get this Title IV-E proposal enacted.

AHRQ Response: Indians and tribes are eligible for all of AHRQ's grant and contract programs–there are no legislative barriers to their participation in AHRQ programs. There is not currently a "set-aside" for Indians in the Department or AHRQ. AHRQ is spending about .95 % of its FY 2000 dollars ($1,938,171 of a total gross budget of $ 203,799,000) on Indian health related matters. AHRQ is trying to increase the amount of Indian health related work it supports by becoming better known among Indian populations. As part of this effort, AHRQ is making wider distribution of grant announcements among Indian populations, plans to once again do a mass mailing to all tribal leaders telling them about the Agency and its work and inviting them to work with AHRQ, and is increasing networking efforts. AHRQ is also looking for opportunities within its own program activities, e.g., the User Liaison Program, to support Indian health related work, and to collaborate with other federal agencies to promote health services research among Indian populations.

AOA Response: 1.9% of AoA's budget goes to the Tribes and/or Tribal Organizations; the National Indian Resource Centers; and the National Indian Council on Aging. 1.76% of this amount goes directly to the Tribes for nutrition and support service programs.

IHS Response: Current Levels - 100% of the agency's budget is expended to provide and support health services for American Indians and Alaska Natives.

ASMB Response: For the last two years, ASMB has hosted–along with the Office of Intergovernmental Affairs–an annual meeting with tribal representatives. The purpose of these meetings is to give Indian people the opportunity to consult with HHS on tribal budgetary needs across the Department. At the meeting to discuss the FY 2002 budget, tribal leaders (and other

representatives of Indian people) made 11 presentations (e.g., HIV/AIDS, Public Health Infrastructure Needs, Welfare Reform, Head Start) and presented written recommendations covering programs run by most HHS Operating Divisions. ASMB has also worked with IHS and HCFA to ensure that the Medicare and Medicaid reimbursements IHS facilities receive are based on their actual costs. As a result of this work, the inpatient per diem rate IHS receives under Medicaid increased by 138% between 1995 and 2000.

CDC Response: In FY 2001, a Budget Initiative targeting AI/AN-specific programs to a level of approximately 1.5% of the total CDC budget was developed, but failed. Various programmatic efforts (such as injury control and cancer control) that target AI/AN populations, and directly fund tribes, have been developed and are currently operational. These were described in our original response to Listening Council issues earlier this year.

FDA Response: N/A

HCFA Response: HCFA does not have complete and accurate data at this time on the percentage of HCFA's budget now going to Indians. Medicaid data for FY 1998 (which have many limitations and short comings) indicate that approximately 1% of Medicaid beneficiaries and 1% of Medicaid vendor payments go to American Indians and Alaska Natives who are also about 1% of the U.S. population. We do not really have comparable data for Medicare or SCHIP. Information from consultations and our own observations lead us to conclude, given the higher rates of Indian families with incomes below the poverty level and the higher incidence of costly health conditions among Indian people, that fewer Indian people are enrolled in our programs than are potentially eligible and that Indian providers may not yet be billing HCFA programs to even the limited degree that they are permitted under current law.

HCFA is engaged in an ongoing process of consultations with Tribes and others interested in Indian health matters. From these consultations we have received a number of recommendations for legislative, regulatory, policy, and operational changes that we are actively considering and, in appropriate cases, implementing. For example, the Department's decision to require waiver of premiums and cost sharing for AI/AN children in SCHIP was designed to remove a significant barrier to Indian children participating in the program. We are presently working on a number of other efforts to increase Indian participation in HCFA programs – as beneficiaries, providers, and consultative partners. HCFA staff also is participating with our colleagues in IHS in providing technical assistance to the Tribal Steering Committee on provisions related to our programs in the re-authorization of the Indian Health Care Improvement Act.

IGA Response: IGA has had preliminary discussion with NGA staff on this issue.

NIH Response: The NIH has embraced the idea of establishing a Center with a focus on coordinating and integrating its efforts, which are aimed at reducing health disparities. Toward that end, the agency has submitted to the Secretary, DHHS, the proposed structure of the center and the proposed functions of each of its components. The Office of Research and Training and the Office of Community-Based Research and Outreach will be two of the most important components of the proposed Center. In addition, a major capacity building program that will be developed and administered at the level of the Office of the Center Director will focus on improving the research infrastructure in TCUs, Hispanic Serving Institutions, Historically Black Colleges and Universities, etc.

SAMHSA Response: The targeted funding for AI/AN-specific programs for FY 1999 was $49,764,000, or 2% of the SAMHSA appropriation ($2,486,787,000) for that year. The FY 2000 estimated amount is $60,398,000, or 2.3% of the appropriation of $2,651,868,000. We assume that FY 2001 obligations will be about the same as the amount spent in FY 2000.

It is important to note that the amounts for the AI/AN-targeted programs do not include other funded grants (both discretionary and block grant programs) in which tribes were recipients of mental health or substance abuse services. It is not possible to determine the total amounts entailed for these other grants, especially due to incomplete reporting by States on their funding to tribes from block grant monies.

Appropriations information related to the issue/issue area (FY00, FY01):

ACF RESPONSE: In FY 00, there was not appropriations action on this issue. In FY 2001, the Department has proposed a $5 million initiative fund multi-year projects under this initiative.

AHRQ Response: AHRQ total funding in FY 2000 was $203,779,000. $1,938,171 was spent on Indian health realted matters (.95%).

AOA Response: Approximately $17,511,300 was appropriated for Indian programs in FY00. Of this, $16,611,300 was funded directly to the Tribes for nutrition and support service programs under Title VI. AoA has requested a 5 million dollar increase in the Title VI funding for FY01

ASMB Response: HHS only tracks funding which is specifically targeted to American Indians and Alaska Natives (AI/ANs). This excludes programs where eligibility is not determined by AI/AN status (e.g., Medicare), programs which are administered jointly with States (e.g. Medicaid), and programs where it is difficult to associate funding with specific individuals (e.g., NIH). For targeted funding, HHS estimates that $3.2 billion will be provided to AI/ANs in FY 2000. Under the FY 2001 budget request, this figure will increase to $3.5 billion. In FY 2000, 6.0% of HHS discretionary funds went to programs which directly target services to AI/ANs.

CDC Response: A set-aside of at least 1.5% of the CDC budget for FY 2000 would have been $45 million and in FY 2001 Pres. Budget Request would have been $49 million; Current levels - the exact percentage of CDC budget going to Indians in FY 2000 is expected to be eight tenths of one percent ($23 million) and in FY 2001 estimated eight tenths of one percent ($24 million).

FDA Response: N/A

HCFA Response: If the Tribal Steering Committee proposals recommending changes to HCFA programs in the re-authorization of the Indian Health Care Improvement Act were enacted into law as presently drafted, they would require substantial increases in appropriations for both services and related administrative costs.

IGA Response: N/A

NIH Response: If established legislatively in the current Congress, the projected budget for the Center in FY01 will be $100 million plus the existing appropriations for minority health research and training which is approximately $97 million for a total of $197 million. This represents the pool of NIH funds to which Native Americans together with ethnic and racial minorities will have better access through relevant and culturally appropriate program development efforts by the NIH. If the Center to be established administratively, its budget in FY01 will be $97M, the existing appropriation for minority health research and training.

SAMHSA Response: See response in Activities to Date.

5. Obstacles to addressing issue/issue area:

ACF RESPONSE: Under current law, tribes are not eligible to receive direct funding under the title IV-E foster care program and may receive funds only by entering into agreements with States. Often, such agreements provide tribes with funds for foster care maintenance payments only, not administrative funds that would enable tribes to build capacity in areas such as staff training, licensing, etc. Approximately 60 tribes now participate in agreements. Congressional action is needed before we can implement this proposal.

AHRQ Response: Since tribes and other Indian organizations currently do not have a great deal of health services research capacity and since funding is largely determined on the basis of scientific and technical merit, fulfilling a set-aside requirement might be difficult.

AOA Response: N/A

ASMB Response: Many factors go into determining the amount of HHS funding which should go to Indian people from a specific HHS program. Most HHS programs do not distribute funds on a per-capita basis. Entitlement programs (e.g., Medicare, Medicaid, TANF) reimburse for specific types of services for individuals without regard to their status as Indian people. Programs such as the National Institutes of Health and the Food and Drug Administration focus on specific disease areas (e.g., cancer, ensuring safety of the food supply) which effect all Americans including Indian people. Most HHS grant

programs award funds competitively although the grantees ability to provide services to groups such as Indian people is often a criterion for funding. To the extent that Indian people do not have appropriate access to HHS program the creation of a set-aside is not always the best solution. Access to some HHS funded services by Indian people could be improved by moving eligibility determination closer to places where Indian people live or making services provided to Indian people a more important criterion in the competition for grant funds.

CDC Response: Lack of funds.

FDA Response: N/A

HCFA Response: The two HCFA programs presently operated by States are Medicaid and SCHIP. Both are extremely complex health insurance programs that require a substantial administrative structure and high level of technical expertise to operate. A legislative change would be needed to permit Tribes to directly operate these programs without going through States. While Tribes successfully operate a number of Federal programs, the Tribal Steering Committee for the re-authorization of the Indian Health Care Improvement Act recognized the significant challenges facing Tribal operation of Medicaid. The Steering Committee only recommended permitting a single Tribal Medicaid demonstration for the Navajo Nation, which has been exploring the feasibility of such an endeavor for some time. The Steering Committee did not similarly recommend limiting new Tribal authority to operate SCHIP; however, we believe similar challenges exist and it may be more prudent to consider testing the concept first with a limited number of Tribal demonstrations. More manageable challenges and a wider range of legislative and administrative options to address them apply to issues such as expanding Indian provider and beneficiary participation in managed care, enhancing outreach and enrollment for eligible Indians in HCFA programs, and addressing gaps in the current ability of Indian providers to bill HCFA programs.

IGA Response: We will need to overcome significant concern among some states over more direct AI/AN and tribal government involvement in federal funding streams.

NIH Response: The only known obstacle at the current time to legislatively establishing the Center is the agenda in the House. It is unknown if the legislation that establishes the Center will be addressed in the House during the current session.

SAMHSA Response: Existing funding to AI/AN populations for mental health and substance abuse services through block grants vary widely among States. National level reporting for the SAPT Block Grant, for example, indicates that many States report little or no funding to tribes, and this minimal funding is not particularly linked to AI/AN low-population States (for example, two of the States are Oklahoma and South Dakota).

6. Srategies to overcome obstacles:

ACF RESPONSE: Advocating for action by Congress, and subsequently providing grants as proposed in the FY 2001 budget.

AHRQ Response: AHRQ is working to help tribes and other Indian organizations become more familiar with the Agency, take more advantage of its programs, and build health services research capacity/infrastructure.

AOA Response: N/A

IHS Response: Legislative Changes:

No changes are needed. With the passage of the Indian Self-Determination and Education Assistance Act of 1975, tribes were given access Federal funds appropriated to the Indian Health Service for the provision of health service services to Indian people. The Indian Health Care Improvement Act of 1976 authorized the funding of health programs provided by and for urban Indian people. Tribes may currently receive funding directly from the Indian Health Service to manage their own health services. They are not required to go through the states to access IHS funding.

ASMB Response: We believe that the annual HHS-wide budget consultation meetings will lead to identification of programs which could play a more critical role in improving the health and welfare of Indian people, identification of barriers which may prevent Indian people from properly accessing these programs, and in strategies for removing these barriers. Consultations conducted by individual Operating Divisions will also help in this regard. Title VI of the recently enacted Tribal Self-

Governance Amendments of 2000 requires the Secretary to study, in consultation with Tribes, the feasibility of operating HHS programs outside of IHS as self-governance demonstration authorities. Among other things, the report will examine the issue of set-asides for Indian people.

CDC Response: See response to #2 above.

FDA Response: N/A

HCFA Response: As indicated above, HCFA will continue to work with Tribes, Indian health programs, and others to use input from consultation to pursue legislative, regulatory, policy, and operational changes to increase access of AI/ANs to our programs.

IGA Response: HHS should meet with tribal and state government leaders, probably on several occasions and in locations around the country, to discuss ways to ensure that tribes have fair access to HHS funded programs.

NIH Response: There are no methods available to the NIH for impacting the activities of the Congress.

SAMHSA Response: Developing options for enhancing the funding of services to tribes, as discussed under "proposed actions," above.

7. OPDIV/STAFFDIV contact on this issue/issue areas (name, title, telephone number:

IHS Response: Robert G. McSwain, Director, Office of Management Support, Indian Health Service, (301) 443-6290

AOA Response: Yvonne Jackson, Director, Office of American Indian, Alaskan Native and Native Hawaiian Programs (OAIANNHP), 202-619-2713

ACF RESPONSE: Alexis Clark, Budget Analyst, Office of Legislative Affairs and Budget 202-401-4530.

AHRQ Response: Wendy Perry, Senior Program Analyst, 301-594-7248

ASMB Response: Nicholas Burbank, Senior Program Analyst, (202) 690-7846.

CDC Response: Ralph T. Bryan, M.D., Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention, c/o IHS Epi Program, 5300 Homestead Rd. NE, Albuquerque, NM 87110, Tel: 505-248-4226, FAX: 505-248-4393, e-mail: rrb2@cdc.gov; and Dean Seneca, Minority Health Specialist, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention MS-D39, e-mail: zkg8@cdc.gov

FDA Response: N/A

HCFA Response: Sue Clain, (HCFA/OL), 202-690-8226

IGA Response: Andy Hyman, Director, Intergovernmental Affairs, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, (202) 690-6060

NIH Response: John Ruffin, Ph.D., Director, Associate Director for Research on Minority Health and Director, Office of Research on Minority Health. Phone: (301) 402-1366.

SAMHSA Response: Steve Sawmelle, Intergovernmental Coordinator, Office of Policy and Program Coordination, (301) 443-0419

SECTION II: SERVICES/SERVICE PROVISION

#1		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Recognize and support the need and use of Traditional Native Healers.	There should be a policy that recognizes use of traditional Native American healers and practitioners in mental health.	IHS, HRSA, ACF, SAMHSA, AHQR

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis. It is the policy of the Indian Health Service to encourage a climate of respect and acceptance in which an individual's private traditional beliefs become a part of the healing and harmonizing force within his/her life. There were at least 10 regional Round Table discussions in Indian Country, but there was not consensus from these meeting that there should be Federal involvement in Traditional Healing at this time. It has been the IHS Director's position that this issue is a local matter and should best be addressed at a local level. He has and continues to advocate for Traditional Healing.

ACF RESPONSE: See Issue #4 of Section I

AHRQ RESPONSE: N/A

HRSA RESPONSE: See Issue #4 of Section I

SAMHSA RESPONSE: NOTE: This issue area is addressed under area #4 of Section I, which also focuses on support for traditional native healers.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: Dr. Trujillo has developed as one of his Initiatives, an emphasis on Traditional Healing and even though it has been unfunded the past three years, we continue to advocate for funding.

AHRQ RESPONSE: AHRQ supports research on alternative and complementary health care and would consider proposals on traditional healing if submitted in response to a "Request for Applications" or its ongoing "Program Announcement," the methods used by the agency to solicit grant applications. AHRQ is also co-funding several studies on alternative and complementary health care with the National Center for Complementary and Alternative Medicine at the National Institutes of Health.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The topic has been presented at many national meetings

AHRQ RESPONSE: N/A

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: Requests were not funded

AHRQ RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: There are many American Indians/Alaska Natives (AI/AN) who do not want the presence of the Federal Government in this arena. There are also many AI/AN who consider themselves Christian and do not want to be involved in

Traditional Healing. Many have objected to being asked in the clinical setting if they had sought the help of a Traditional Healer or would they like to have the services made available for them.

AHRQ RESPONSE: AHRQ has not funded many grants in the area of complementary and alternative medicine.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: Because the obstacles are on both sides, it appears there will need to be more work in gaining true consensus on this issue. Many of the Elders do not want Federal involvement in any way. Especially they have been adamant about the payment of these services from an outside source. The payment of the healing process is often part of the healing process!

AHRQ RESPONSE: Interested tribes can submit proposals to AHRQ under the broad authority of its "Program Announcement." Tribes could also seek co-sponsorship by AHRQ and another agency, such as the National Center for Complementary and Alternative Medicine.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: Kermit C. Smith, D.O., M.P.H., Chief Medical Officer, Office of the Director, Indian Health Service, (301) 443-1083

AHRQ RESPONSE: Wendy Perry, Senior Program Analyst 301-594-7248

SECTION II: SERVICES/SERVICE PROVISION

#2		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Need to improve/provide access to specialty and inpatient care, behavioral health services (including services for incarcerated youth), alcohol/substance abuse programs that include services for children, adolescence and women, diabetes programs, prevention and health education, pre-hospital emergency medical services, hospice and physical therapy programs, long-term elderly care, in-home or special transportation for disabled people. Refer to Issue #8	• IHS should be given authority to license long-term health care units on reservations. • Support in obtaining ambulances to provide 24-hour coverage.	IHS, HCFA, SAMHSA, ACF, HRSA, AOA, CDC

1. **Public Law(s) or authorization related to this issue/issue area:**

ACF RESPONSE: Public Law 106-71 (U.S.C. 5701 – Family Youth Services Bureau -FYSB - The purpose of FYSB is to provide national leadership on youth issues and to assist individuals and organizations in providing effective, comprehensive services for youth in at-risk situations and their families. A primary goal of FYSB programs is to provide positive alternatives for youth, ensure their safety, and maximize their potential to take advantage of available opportunities. The Bureau's authorizing legislation, Section 302, makes provisions for services for at-risk runaway and homeless youth as an alternative to involving law enforcement, child welfare, The law does not cover services for incarcerated Youth. (Note: The Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the Justice Department provides services for this category of youth.)

IHS RESPONSE:
The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

HCFA RESPONSE: Refer to response for Issues #1 and #8 of Section I.

CDC RESPONSE: Of the issues/issue areas listed above the following would be included in CDC activities: alcohol/substance abuse programs (prevention activities), diabetes programs, and prevention and health education — most of which are contained within our response to Issue #5 of Section I. Public Health Service Act, particularly Title III, General Powers and Duties of the Public Health Service.

HRSA RESPONSE: See Issue #8 of Section I

SAMHSA RESPONSE: NOTE: SAMHSA's responses under this issue area are include in issue areas #'s 4, 8, and 15 of Section I.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

ACF RESPONSE:
This issue area does not contain a specific all inclusive youth issue that FYSB is authorized to address. However, the youth aspect of the issue below is addressed in turns of the services available to at-risk Native American youth who are not incarcerated. Concerning inadequate services for women, elders, and youth, the FYSB has the following action steps to increase services to Native American Youth:

The FYSB will identify a staff person who will serve as a liaison with the Administration for Native American (ANA) to assist ANA in the provision of current and relevant information concerning the Runaway and Homeless Youth program and the services provided in Native American communities. ACF Central and Regional Office staff will provide electronic/telephonic technical assistance to Tribes interested in applying for RHY grants. The FYSB fiscal year 2001 program announcement will specifically target Federally recognized Indian Tribes and Tribes that are not federally recognized and urban Indian organizations.

IHS RESPONSE: The issues are similar to those listed in item #9 and the proposed agency actions are the same.

HCFA RESPONSE: Granting IHS the authority to license long-term health care units on reservations would require legislation, as current legal authority at section 1864(a) of the Social Security Act does not allow HCFA to permit IHS to perform this activity. The Special Needs Report to Congress recommends that States consider the experience providers when establishing managed care networks, particularly for individuals with special health care needs. HCFA will be implementing this recommendation through its final Medicaid managed care regulation, which is under development. We believe these mechanisms will help ensure that enrollees with special health care needs receive the necessary and appropriate access to experienced specialty providers.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

ACF RESPONSE:
FYSB administers three Runaway and Homeless Youth grant programs that support locally- based youth services and one demonstration grant program, the Youth Development State Collaboration Projects. The Youth Development State Collaboration Projects are designed to assist the States in the development and promotion of positive youth development initiatives within their respective States.

- Basic Center Program: Funds youth shelters that provide emergency shelter, food, clothing, outreach services, and crisis intervention for runaway and homeless youth. The shelters also offer services to help reunite youth with their families, whenever possible. Federally recognized Indian Tribes are eligible to apply. Indian Tribes that are not federally recognized and urban Indian organizations are also eligible to apply for grants as private, non-profit agencies.

- Transitional Living Program for Homeless Youth (TLP): Developed in response to the longer term needs of older homeless youth, the goals of the TLP are to assist such youth in developing skills and resources to promote independence and prevent future dependency on social services. Housing and a range of services are provided for up to 18 months for youth ages 16-21 who are unable to return to their homes. Federally recognized Indian Tribes are eligible to apply. Indian Tribes that are not federally recognized and urban Indian organizations are also eligible to apply for grants as private, non-profit agencies.

- Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless, and Street Youth Program (SOP): FYSB awards additional resources to organizations serving runaway, homeless and street youth to provide street-based outreach and education to prevent the sexual abuse and exploitation of these young people.

- Youth Development State Collaboration Project: The Youth Development State Collaboration Projects enable the States to develop new or strengthen existing effective youth development strategies. Any State or Federally recognized Indian Tribe is eligible to apply.

The availability of FYSB grant funds are published annually in the Federal Register. Interested applicants should look for the announcement generally in the spring of each year and follow the published instructions.

Determination of Funding Amounts:

- Basic Center Programs: Priority is given to applicants who apply for less than $200, 000 per year. The maximum Federal share for a 3-year project period is $600,000.

- Transitional Living Program: Applicants may apply for up to $200,000 per year, which equals a maximum of $600,000 for a 3-year project period.

- Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless, and Street Youth Program: Applicants may apply for up to $100,000 in Federal support each year, a maximum of $300,000 for a 3-year project period.

Youth Development State Collaboration Projects: Applicants may apply for up to $120,000 in Federal support each year, which equals a maximum of $360, 000 for a 3-year project period.

IHS RESPONSE: As noted in Issue #9, the agency continues to provide analysis and advocacy for these program enhancements to Congress. The agency also continues to advocate with other HHS elements as appropriate (e.g., HCFA for funding of elder care)

HCFA RESPONSE: N/A

4. Appropriations information related to the issue/issue area (FY00, FY01):

ACF RESPONSE: In FY 1999 tribal grantees received $680,936 in Runaway and Homeless Youth Program funding.

IHS RESPONSE: N/A

HCFA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**
ACF RESPONSE: N/A

IHS RESPONSE: Despite the change from Federal deficits to Federal surpluses the budget caps established by the Balanced Budget Act of 1997 remain in affect through FY 2002. The FY 2001 budget allocation provided for the House Interior Appropriations Subcommittee was $302 million below the FY 2000 level and $1.7 billion less than the amount requested by the Administration. While the Senate Interior Subcommittee has received a budget allocation that is greater than the House's, it is still significantly below the President's request. The President has proposed discretionary spending limits at levels necessary to serve the American people, including American Indians/Alaska Natives. The Administration has consistently reminded Congress that the allocation to the Interior Subcommittees is insufficient to make the necessary investments in Indian programs.

HCFA RESPONSE: N/A

6. **Strategies to overcome obstacles:**
ACF RESPONSE: N/A

IHS RESPONSE: The Indian Health Service needs to continue to present the health care needs of Indian people in such a way that our budget is a top priority whenever funding allocation decisions are made. This will include consulting with tribal representatives, and working with staff from HHS, OMB and the Appropriations Committees, to ensure that the information needed to make the most compelling possible case is presented in a timely manner.

HCFA RESPONSE: N/A

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

ACF RESPONSE: Dorothy Pittard, Program Analyst/FYSB, (202) 205-8906

IHS RESPONSE: W. Craig Vanderwagen, M.D., Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service., (301) 443-4644

HCFA RESPONSE: Linda Brown (HCFA) – (202) 690-8172

SECTION II: SERVICES/SERVICES PROVISION

#3		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Need for dialysis units and to increase the size of existing units.		HCFA, HRSA, IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

HCFA RESPONSE: Title II and Section 1881 of Title XVIII of the Social Security Act governs the coverage of End State Renal Disease (ESRD) – Dialysis.

HRSA RESPONSE: N/A

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The agency proposes to examine the appropriateness of expanded hemo-dialysis services versus the enhancement of other strategies for management of End Stage Renal Disease (ESRD). This examination will be conducted with the participation of the Tribes.

HCFA RESPONSE: HCFA does fund dialysis units. Providers need to make requests to HCFA and/or HCFA's contractors. HCFA contracts nationwide with ESRD Network Organizations located in 18 geographically-designated areas. The internet site for information on these networks is http://www.networks.org/. The HCFA site for ESRD information is http://www.hcfa.gov/quality/qlty-5d.htm.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The agency's senior clinician in renal disease has been analyzing the data sets of both IHS and HCFA regarding the issues of treatment of ESRD and visited many communities to review the issues on a local basis. He will provide this analysis to tribal leadership in consideration of expansion of dialysis activities or other approaches to treatment of ESRD (including transplantation, home dialysis, etc.).

HCFA RESPONSE: HCFA has funded dialysis units for the Indian Health Service.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: In FY 2000 $50M was appropriated for hospital construction. In FY2001 $65M was requested for construction, but this did not include planned space for hemodialysis units.

HCFA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: The funding of construction and staffing has been extremely limited in the recent past and the planning assumptions of the agency have not included hemodialysis units.

HCFA RESPONSE: Information needs to be issued to Tribes as they express interest, and Tribes need to understand that they can get help and information regarding the need for dialysis units.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: Tribal consultation with agency professionals is needed to assess the desirability of this approach. The agency currently accesses dialysis through the HCFA-funded ESRD program and private providers are located in many Indian communities to provide these services. This strategy has reduced the pressure on the contract health budget as well as reduced the challenges in recruiting and retaining qualified highly specialized professional staff for these activities. In some communities the rise in demand has exceeded the ability of providers to expand services. The consultation process will provide information that will allow communities to anticipate needed expansions in a more timely manner and assist in targeting secondary and tertiary prevention strategies for reducing demand (or at least delaying demand).

HCFA RESPONSE: Offer tribes consultation sessions, the name and telephone number of the contact at HCFA Central Office and the internet sites available for information and assistance.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: W. Craig Vanderwagen, M.D., Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service, (301) 443-4644

HCFA RESPONSE: Judith Kari (HCFA) – (410) 786-6829.

SECTION II: SERVICES/SERVICES PROVISION

#4		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Lack of access to "charity care."		IHS, HCFA

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

HCFA RESPONSE: A payment adjustment is provided for hospitals that serve a disproportionate share of low-income patients. The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location. This provision is described in section 1886(d)(1)F)(i) of the Social Security Act and implemented at 42 CFR 413.130. Section 1932 of the Social Security Act requires States to make additional Medicaid payments to hospitals that qualify as disproportionate share hospitals (DSHs). DSHs serve a high number of low-income (e.g., charity care) and Medicaid beneficiaries.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The agency interprets this issue as a concern about access to Medicaid or Medicare funded services outside IHS facilities. The agency proposes to work with HCFA to assure access to HCFA funded services for eligible American Indians and Alaska Natives.

HCFA RESPONSE: IHS or tribal hospitals that are Medicaid providers may qualify for additional reimbursement under DSH under section 1932 of the Act. States should strive to make these payments to the fullest extent possible. HCFA will communicate to States that DSH payments are available for IHS and Tribal hospitals.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The IHS and HCFA have worked collaboratively to address reported civil rights violations where local health care providers have denied services to otherwise eligible Indian people. In addition, the two agencies have a working group that monitors State Medicaid activities through the assessment of waiver requests and policy advisories issued to the States regarding services to American Indians and Alaska Natives.

HCFA RESPONSE: At the outset of the Medicare rate setting in December 1998, it was determined that IHS hospitals were entitled to DSH payments. After further inquiry and review we discovered that some hospitals were receiving DSH payments on an interim basis. It was agreed that IHS would supply the fiscal intermediary with the Title XIX data and the intermediary would calculate the DSH payments ad make any retroactive adjustments.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: No specific appropriations are associated with this issue.

HCFA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: Despite the change from Federal deficits to Federal surpluses the budget caps established by the Balanced Budget Act of 1997 remain in affect through FY 2002. The FY 2001 budget allocation provided for the House Interior Appropriations Subcommittee was $302 million below the FY 2000 level and $1.7 billion less than the amount requested by the Administration. While the Senate Interior Subcommittee has received a budget allocation that is greater than the House's, it is still significantly below the President's request. The President has proposed discretionary spending limits at levels necessary to serve the American people, including American Indians/Alaska Natives. The Administration has consistently reminded Congress that the allocation to the Interior Subcommittees is insufficient to make the necessary investments in Indian programs.

HCFA RESPONSE: State commitment is necessary to make DSH payments. However, the States may not be willing to make large DSH payments to IHS facilities or tribal hospitals since it will draw down the Federal DSH allotment, reducing the availability of Federal DSH dollars for payments to State government-owned DSHs.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: The Indian Health Service needs to continue to present the health care needs of Indian people in such a way that our budget is a top priority whenever funding allocation decisions are made. This will include consulting with tribal representatives, and working with staff from HHS, OMB and the Appropriations Committees, to ensure that the information needed to make the most compelling possible case is presented in a timely manner.

HCFA RESPONSE:
Communicate to States that DSH payments are available to for IHS and Tribal hospitals.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: W. Craig Vanderwagen, M.D., Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service, (301) 443-4644

HCFA RESPONSE: Medicaid: Christine Hinds (HCFA) – (410) 786-4578 ; Medicare: Ann Pash (HCFA) – (410) 786-4516

SECTION II: SERVICES/SERVICES PROVISION

#5		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Need to increase focus on cancer screening for men.		HRSA, IHS, NIH, AOA

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

AOA RESPONSE: N/A

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The agency has cancer screening activities available for both genders. It proposes to provide information on the cancers for which American Indian and Alaska Natives appear to be at high risk. Life style choices are a critical factor in most cancers and many are preventable. The cancer risks in American Indian and Alaska Natives males are generally the same as the general U.S. population, but additional research may be warranted in certain cancers. The agency proposes to work with tribes and NIH to identify research priorities aimed at understanding cancer among AI/AN males.

AOA RESPONSE: AoA could promote cancer screening for men at the senior centers as part of health education.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The agency has initiated dialogue with NIH on strategies for consultation and examination of tribal priorities in research. In addition, the two agencies are working towards the development of a stronger cadre of AI/AN research scientists to enhance culturally relevant research studies. The screening activities are currently available in many IHS funded programs but utilization rates are low. Appropriate health education and outreach efforts have been explored.

AOA RESPONSE: N/A

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: No budget activity is identified for this activity.

AOA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: The primary obstacles are: 1). Lack of full funding for both screening and outreach; and 2). Education in the community about risk populations and behaviors which inhibit utilization of services where they are available.

AOA RESPONSE: This has not been a priority in the Title VI program to date.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: Full funding of clinical programs and the health education activity in the IHS budget would be helpful. Secondarily, additional support for screening and outreach could be provided by CDC and elements of NIH. These resources need to be more fully accessed. Many of the clinical screening activities can be funded by HCFA where individuals are eligible for HCFA programs. Full utilization of these resources would expand the availability of screening, if not the utilization.

AOA RESPONSE: AoA will provide Title VI grantees with information to share with elders.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

IHS RESPONSE: W. Craig Vanderwagen, M.D., Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service, (301) 443-4644

AOA RESPONSE: M. Yvonne Jackson, Director, OAIANNHP, (202) 619-2713

SECTION II: SERVICES/SERVICES PROVISION

#6		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Need to provide holistic services for families (i.e., mental health services).		IHS, SAMHSA

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

SAMHSA RESPONSE: 42 USC, 290ff, 42 USC, 290aa

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The agency fully supports this concept and proposes to enhance activities to assure a more holistic approach.

SAMHSA RESPONSE: For the Circles of Care and Child Mental Health Initiative, see issue area #'s 4 and 15 of Section I. The Sacred Child Project will be funded through FY 2002.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The agency has reorganized its mental health, alcohol, and other behavioral services into a single unit to promote a more holistic team approach to care in behavioral health. The agency has supported the development of the draft language for reauthorization of Title VII of the Indian Health Care Improvement Act. The draft language would provide strengthened authority for the delivery of holistic care in behavioral health.

SAMHSA RESPONSE: In demonstration projects to improve the mental health system of care, tribal grantees in the Circles of Care program and the Child Mental Health Initiative are using a holistic approach to integrate services and make them family-based and culturally competent. The Sacred Child Project is a grant project funded by CMHS, FY 2000 through FY 2002, which is located at United Tribes Technical College in Bismarck, North Dakota. It provides comprehensive community-based mental health services to children with serious emotional disturbances from four tribal communities.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: Alcohol and mental health combined appropriations were approximately $140M in FY2000 and a total of approximately $149M is proposed by the President for FY2001.

SAMHSA RESPONSE: Sacred Child Project - FY 2000 - $500,000

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: Resistance to this concept is minimal and highly supported at the community level with many tribes organizing their programs in a unified manner (95% of the alcohol programs are tribally operated and 50% of the mental health programs are tribal).
SAMHSA RESPONSE: Philosophical differences between disciplines, such as some substance abuse treatment programs' resistance to traditional tribal approaches to care.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: Continued support for reorganization and cross training of professionals will further expedite the process of a more holistic approach.

SAMHSA RESPONSE: Encourage cross training and interdisciplinary treatment planning.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: W. Craig Vanderwagen, M.D., Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service, (301) 433-4644

SAMHSA RESPONSE: Steve Sawmelle , Intergovernmental Coordinator , Office of Policy and Program Coordination, (301) 443-0419

SECTION II: SERVICES/SERVICES PROVISION

#7		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Medicare/Medicaid Outreach: Unable to obtain services for families when parents are not legally married (i.e., man not on Medicaid application)		ACF HCFA

1. **Public Law(s) or authorization related to this issue/issue area:**

HCFA RESPONSE: Under Federal regulations at 42 CFR 435.930, States have a continuing obligation to provide Medicaid to all persons who have not been properly determined ineligible for Medicaid. Where individuals have not been properly determined ineligible, they continue to be eligible for Medicaid; reinstatement is compelled as part of the State's continuing obligation to provide Medicaid. Further, States must affirmatively explore all categories of eligibility before it acts to terminate Medicaid coverage.

ACF RESPONSE: There is no ACF legislative provision or program regulation that limits services to children and or their families based on the marital status of those families being served.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

HCFA RESPONSE: Continue to encourage States to conduct outreach activities aimed at informing families about health care coverage available through Medicaid and SCHIP and ensuring that all those eligible are enrolled in the programs.

ACF RESPONSE: Not applicable.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

HCFA RESPONSE: Over the past few years, States have made enormous progress increasing access to health care coverage for low-income families. As a result of eligibility expansions, simplified enrollment procedures, and creative outreach campaigns, millions more low-income children and parents are eligible for health care coverage through Medicaid or SCHIP. The de-linkage of Medicaid from cash assistance has made it possible for States to offer low-income families health care coverage regardless of whether the family is receiving welfare. HCFA has been working closely with States to outline specific actions that all States must take to identify individuals and families who have been terminated improperly and to reinstate them to Medicaid, as well as perform outreach to ensure that all who are eligible for Medicaid receive coverage. We have provided this guidance to States through fact sheets, letters to State Medicaid Director Letters (the most recent dated April 7, 2000), updates to the State Medicaid manual, and the publication of a 28-page, plain-English guide entitled, "*Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World.*"

ACF RESPONSE: Not applicable.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

HCFA RESPONSE: N/A

ACF RESPONSE: Not applicable.

5. **Obstacles to addressing issue/issue area:**

ACF RESPONSE: Not applicable.

HCFA RESPONSE: N/A

6. **Strategies to overcome obstacles:**

HCFA RESPONSE:
Continued technical assistance to States to ensure that they are pursuing all available avenues to achieving 100% enrollment in Medicaid.

ACF RESPONSE: Not applicable.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

HCFA RESPONSE:
Marty Svolos (HCFA) – (410) 786-4582

ACF RESPONSE: N/A

SECTION II: SERVICES/SERVICES PROVISION

#8		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Medicare/Medicade Outreach	Outreach: • Develop brochure describing Medicare benefits • Provide information on Medicare/Medicaid in plain language.	HCFA

1. **Public Law(s) or authorization related to this issue/issue area:**

HCFA RESPONSE: Titles XVIII, XIX and XXI of the Social Security Act

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
HCFA RESPONSE: Continue working with Tribes Indian Health Service and AI/AN advocacy groups in the development of health promotion and outreach strategies, as well as develop materials, which are culturally appropriate for Indian people , i.e. in Indian dialects, audio and written materials which explain Medicare, Medicaid and SCHIP.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
HCFA RESPONSE: HCFA has awarded contracts to provide information to AI/AN populations about its major programs. For example, HCFA has funded projects with Tribes to develop outreach materials regarding Medicare + Choice and related programs; including the program serving individuals dually eligible for Medicare and Medicaid. HCFA has funded a larger initiative that produced outreach materials for elderly and disabled AI/ANs potentially eligible for both Medicare and Medicaid.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
HCFA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**
HCFA RESPONSE: To date, outreach materials, which have been developed only, reach a limited number of Tribes. More educational activities, including consultations with Tribes and the execution of intra-agency agreements between HCFA, IHS and other HHS agencies need to be pursued and funded.

6. **Strategies to overcome obstacles:**
HCFA RESPONSE: Expand the activities and funding associated with items 2 and 3 above.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
HCFA RESPONSE: Joyce Williams (HCFA) Project Officer – (410) 786-5416 Belen Rodrigues (HCFA) Project Officer – (410) 786-0543

SECTION II: SERVICES AND SERVICE PROVISION

Issue #9		
Issue/Issue Area	**Tribal Recommendation**	**OPDIV/STAFFDIV Assigned**
Inpatient Treatment is too short	Concern was raised that inpatient treatment for 28 days is not sufficient to address the multiple drug, alcohol and mental health problems experienced by Indian youth. Longer treatment is needed. Also what is available for those people returning to their communities from treatment? Support for longer treatment is needed.	IHS SAMHSA

1. **Public Law(s) or authorization related to this issue/issue area:**

IHS Response: The Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986, Public Law (P.L.) 99-570 (Anti-Drug Abuse Act of 1986. The Anti-Drug Abuse Act of 1988, P.L. 100-690 (Omnibus Drug Bill Amendments) , P.L. 102-573, October 29, 1992, Title VII, Substance Abuse Program has reauthorized the aforementioned P.L. 99-570 and P.L. 100-690 components. Indian Self-Determination and Education Assistance Act (P.L. 93-638), passed in 1975 Indian Health Care Improvement Act, P.L. 94-437 of 1976.

SAMHSA Response: 42 USC 290aa; and 42 USC 290ff

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

IHS Response: Evaluation of the Adolescent Regional Treatment Centers and the Evaluation of the Effectiveness of the Indian Health Service Sponsored Alcohol and Substance Abuse Aftercare/Continuing Care/Maintenance Care Program is continuing. Continue software and data development and coordination for measuring the substance abuse and underage alcohol problems among American Indians and Alaska Natives; Support ongoing I/T/U programmatic evaluation and research toward developing effective prevention and treatment services; IHS goals and objectives are also consistent with the Federal drug control priorities by focusing on community awareness, primary and secondary prevention strategies, collaboration, and services for special population groups. The Public Health Service Plan to Reduce the Demand for Illicit Drugs (June 1989) requires the IHS to expand its efforts in treating intravenous drug abusers in specialty clinics and treating other drug abusing youth in federally-funded health centers and programs for the homeless; National leadership that focuses on youth treatment, community education, and prevention services for high-risk youth; Publication and dissemination of an update FAS/FAE resource manual.

SAMHSA Response: Substance abuse treatment grants may be awarded, for example, to tribes and tribal organizations, as well as to units of local government (cities, towns, counties). Substance abuse treatment programs provide services for varied treatment terms. Residential treatment services are provided in some programs for up to one year. The applicant puts forth the term of service, the types of services provided and expected outcomes. The treatment terms are based on the type of treatment and needs assessed for each individual client. SAMHSA's Center for Substance Abuse Treatment (CSAT) will continue to provide grants in the Targeted Capacity Expansion, Exemplary Practices for Adolescents, and Practice/Research Collaborative programs. Such funding, as it relates to AI/AN tribes, will help toward reducing the need for extended residential treatment, including that for tribal youth.

In the area of mental health, SAMHSA's Center for Mental Health Services (CMHS) will continue to provide grants and tribally specific technical assistance to seven tribal grantees of the Child Mental Health Initiative. The focus of the program is community based care for children and youth, including those returning from inpatient treatment. New grants will not be issued in FY 2001. CMHS plans to offer a new cycle of the tribally targeted Circles of Care grants in FY 2001, consisting of 3-year grants to tribal and urban Indian programs to plan and assess a culturally appropriate, community based system of care for children, youth and families with serious emotional problems.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

IHS Response: The Chemical Dependency Management Information System, the Mental Health/Social Services (MH/SS). These RPMS software packages are now available to all the Areas of the Indian Health Service, including tribes and Urban programs; Continued enhancement of Youth Regional Treatment Center development and effectiveness of treatment services including development of continuity of care/aftercare/maintenance care plans for client's return to their respective community;

An evaluation of the adolescent regional treatment centers, an RTC Outcomes Tracking Protocol Project has begun in FY 1998. The purpose of this protocol is to provide a quantitative means for validly and reliably documenting client progress, program outputs, program and policy outcomes and program and policy efficiency; Continue prevention and education programs that target youth to reduce their use of illicit drugs, alcohol, and tobacco products. For instance, the Indian Health Care Improvement Act Amendments have identified funds for use by urban Indian health clinics to provide treatment, rehabilitation, and education services for Indian youth with substance abuse problems; Support of inhalant abuse prevention and treatment initiative training, publications, and education to tribal communities in regards to children and young adolescent use; Continued support to address specific needs of women and their children via recommendations from the Women's Four Phase Evaluation Report, in which two phases have been completed. The first two phases of the four-phase evaluation have been completed. The final report of the first two phases described the conditions of and reasons for seeking treatment by AI/AN women. Among other things, these included high rates of abuse as children and adults and women's motivation to become better parents. The final report also emphasized need for treatment programs that provide cultural, spiritual and child care activities, and the importance of completion of individual and group therapy and participation in support groups. Information from the final report of the first two phases has been presented throughout Indian country, and at professional meetings in the U.S. and Canada. Phase III and IV of this evaluation have begun, and will conclude in 2001. The purpose of Phases III and IV are to assess and measure the treatment outcomes achieved by the women receiving treatment at facilities supported by the Indian Health Service. In addition, the evaluation study will attempt to relate treatment outcomes to the treatment services provided. It will also

describe the organization and provision of substance abuse treatment and aftercare/maintenance care/continuing care services available for adult AI/AN women, identifying common strengths, problems, and recommendations for improvement.

Over the past four years the Indian Health Service ASA Program has collaborated with the Centers for Disease Control and Prevention on several important projects. They include, a maternal alcoholism and substance abuse screening instrument for use at I/T/U prenatal clinics; a case control study on maternal characteristics of Indian mothers of FAS children; An analysis and dissemination of American Indian and Alaska Native Behavioral Risk Factor Surveillance System data has been completed; and The Program continues to expand toward a comprehensive continuum of care encompassing prevention, education, treatment and rehabilitation. Workshops on American Society of Addiction Medicine Patient Placement Criteria are sponsored as part of the Clinical and Preventive Health Leadership Series.

SAMHSA Response: Forty-seven tribes or tribal organizations have received grants in CSAT's substance abuse treatment programs noted above. There are 44 Targeted Capacity Expansion grantees, two Practice/Research Collaborative grantees, and one Exemplary Practices for Adolescents grantee. Grants serving AI/AN families should have a positive impact on youth and reduce the need for extended residential treatment away from home. It should be noted that SAMHSA's substance abuse policies support the need for whatever follow-up or relapse prevention services may be necessary to transition individuals back to the community.

Through CMHS' Child Mental Health Initiative, eight tribal communities have been funded to increase community based care for children and youth, including those returning from inpatient treatment. A major objective of the grant program is to improve and increase capacity in the community to reduce the need for inpatient treatment which is often located hundreds of miles away from the rural reservation sites, making it difficult for families to participate in discharge and treatment planning. Several of the grantees are working with other community programs to develop shelter/therapeutic group homes in the communities. The grants do not fund inpatient treatment.

Nine tribal and urban Indian communities have been funded through CMHS' Circles of Care program to plan, coordinate, and assess mental health services for their children, youth and families. Aftercare from treatment is a major unmet need, and is being addressed in community focus groups, to gain consensus for solutions. With technical assistance for evaluation and program development, the communities are developing increasingly competitive needs assessments for funding new services.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

IHS Response:

FY 2000 ASA = $ 96,824M MH/SS = $43,245 M
FY 2001 ASA = $100,541M MH/SS = $45,117 M

SAMHSA Response:

Targeted Capacity Expansion
FY00 - $114 million ($29.4 million for AI/AN)
FY01 - $163 million ($29.4 million for AI/AN)
(preliminary figure from Conference Action)

Practice/Research Collaboratives
FY00 - $3.1 million ($650,000 for AI/AN)
FY01 - $2.7 million ($400,000 for AI/AN)

Exemplary Practices for Adolescents
FY00 - $4.3 million ($430,000 for AI/AN)
FY01 - $2.2 million ($430,000 for AI/AN)

Child Mental Health Initiative:
FY00 - $82.7 million ($7.2 million for AI/AN)
FY01 - $86.8 million ($(7.2 million for AI/AN)
Circles of Care:
FY00 - $2.4 million for AI/AN
FY01 - $2.4 million for AI/AN

5. **Obstacles to addressing issue/issue area:**

IHS Response:

a. Inconsistent coordination and communication with tribal and Federal availability of dollars dilutes programmatic focus,
b. Denial is the first hallmark of addiction, service providers would rather say they are doing all they can, rather than do something different.

SAMHSA Response: Some of the obstacles that the CSAT-funded programs face are a lack of sufficient culturally competent services for AI/AN people in urban settings, few employment opportunities in the local communities for clients completing treatment, and lack of AI/AN resource material (published best practices and service models) to replicate successful programs in other AI/AN communities.

The CMHS grants seek to change the system of care and risk facing resistance, differing treatment philosophies, priorities, and professional rivalries between providers in the communities. The aftercare services could be more effective if they were coordinated; for example, provided in the school setting by mental health and substance abuse counselors who are cross trained and do regularly scheduled case conferencing.

6. **Strategies to overcome obstacles:**

IHS Response:

Main solutions:

a. Coordinated Intensive case management
b. Full continuum of services with emphasis on continual assessment, relapse prevention, and community support systems.
c. Effective, efficient collection and use of outcomes data.

Suggestions for collaboration(s):

Revisit the Memorandum of Agreement that as been established between SAMHSA, BIA and IHS to coordinate activities in this regard. Urban Indians will continue to be addressed in the course of present drug control activity within IHS.Expand primary prevention efforts via collaboration with the Center for Substance Abuse Prevention, SAMSHA, BIA, DOJ, etc...on issues such as the Rural and Remote Culturally Distinct population, Youth detention, Treatment drug courts, Community mobilization provider training, Violence Prevention, and Facilitation Skills Development. For example, the Gathering of Native Americans is a local, community based training curriculum being widely adapted throughout Indian country. These workshops and events have been designed, tested, and evaluated in American Indian communities with the help of Indian education, social services and health professionals supported by both the Indian Health Service and the Center for Substance Abuse Prevention. As a result, there has been a revitalization of alcoholism and substance abuse, community planning interest and capability), other areas and interventions continue to be explored as well.

SAMHSA Response: Grantee programs need encouragement to feel comfortable with publishing service models, findings and outcomes to assist other tribes with program development. CSAT provides technical assistance in packaging successful programs for replication, and will endeavor to make tribes feel receptive to requesting such assistance.

CMHS funding provides staffing, activities, and training conferences to permit grantee communities to learn from each other. Technical assistance contracts will continue with the National Indian Child Welfare Association for program development and the National Center for American Indian and Alaska Native Mental Health Research for the cross-site evaluation to support the grant programs.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

IHS Response: Craig Vanderwagen, M.D., Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service, (301) 443-4644

SAMHSA Response: Steve Sawmelle, Intergovernmental Coordinator, Office of Policy and Program Coordination, (301) 443-0419

SECTION III: CARE PROVIDERS

#1		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Too few health care providers results in high patient care load - specific requests for: • Psychiatrists, Mental Health Professionals trained in inhalant use • Clinical Health Nurses • Community Health Representatives	IHS must use existing options to encourage careers in IHS (i.e., Federal Loan Repayment Program) and enhance training of Native Americans in health professions.	HRSA IHS SAMHSA

1. **Public Law(s) or authorization related to this** issue/issue area:

IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

HRSA RESPONSE :

- NURSING ---- "The Health Professions Education Partnerships Act of 1998," Public Law 105-392, signed by President Clinton on November 13, 1998, amends the Title VIII of the Public Health Service Act, Subtitle B is "The Nursing Education and Practice Improvement Act of 1998."
- HEALTH PROFESSIONS ALLIED HEALTH ---- Section 755 of the Public Health Service Act, 42 U.S.C. 294e
- MEDICINE/DENTISTRY ---- The Division of Medicine and Dentistry (DMD) grants, under Title VII of the Public Health Service Act are awarded to public or private nonprofit hospitals, schools of medicine or osteopathic medicine, or public or private nonprofit entities which have provisions of medical or dental education as one of their major functions. To address the issue of American Indian/Alaska Natives health care providers and medically underserved communities, a statutory funding preference and/or a special consideration is given to grant applicants meeting the following criteria. Section 791(a) of the Public Health Service Act provides that a statutory funding preference will be given to any qualified applicant that: (A) has a high rate for placing graduates in practice settings have the principal focus of serving residents of medically underserved communities: of (B) during the two year period preceding the fiscal year for which such an award is sought, has achieved a significant increase in the rate of placing graduates in such settings. This statutory funding preference is only applied to applications that rank above the 20th percentile of applications recommended for approval by the peer review group. Special consideration will be given to projects which prepare practitioners to care for underserved populations and other high risk groups such as the elderly, individuals with HIV/AIDS, substance abusers, homeless, and victims of domestic violence.
- PSYCHOLOGY --- Executive Order 13201 of October 19, 1996 "Tribal Colleges and Universities"
- HCOP --- HCOP grants are funded under the "Health Professions Education Partnerships Act of 1998", PL 105-392.

SAMHSA RESPONSE: 42 USC, 290ff, 42 USC, 290aa

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issue area:**

IHS RESPONSE: Seek continued funding for the programs described below and manage them in a way that maximizes the number of participants.

HRSA RESPONSE:

- NURSING ---- Provide Technical Assistance and Consultation for Grant Applicants. On site visits to Grantees planned for Fall, 2000. American Indian Nurse representatives to National Advisory Council on Nurse Education and Practice Council, Peer Review Panels, Funding Methodology Allocation Advisory Panel, and other projects and programs of the Division of Nursing Staff participation at National Association of Native Alaska / Indian Nurse Association meetings. Encourage linkages and partnerships with Tribal Colleges and Universities, reservation schools, and other public and private institutions. Include American Indian Nurses in displays portraying a positive and diverse image of nursing. Washington Internships for Native Students (WIN) Summer Internship Program . Support to sponsor an intern in the Division of

Nursing Cooperative Agreement with the American University and American Higher Education Consortium Summer 2001.

- HEALTH PROFESSIONS ALLIED HEALTH ---- through grants--- a priority is given to applicants who provide community-based allied health training experiences and address Tribal colleges and Universities serving Native Americans-- one grant from a TCU was approved this year but may not be ranked to be funded.---- through technical assistance at a workshop in Phoenix AZ at Tribal Colleges Annual Mt ---- include Native Americans in the allied health peer review panels ---- through publications, The Allied Health Professions: Opportunities for Minority Students, to encourage minority students including Native Americans to explore opportunities in the allied health professions
- MEDICINE/DENTISTRY ---- At present, George Blue-Spruce, Jr., DDS, MPH, is a member of the Advisory Committee on Training in Primary Care Medicine and Dentistry. For FY 2001, the DMD will continue to include American Indians/Alaska Natives on all peer review panels and on advisory boards.
- PSYCHOLOGY ---- All seven Tribal Colleges received two modules in January 2000. Five of the Tribal Colleges implemented at least one of the modules into their curriculum this spring; the remaining two are planning to implement at least one module in summer 2000. HCOP GRANT. The UM Department of Psychology submitted a grant application in January 2000 for HCOP funding. The grant proposal links the UM with the seven Tribal Colleges in the state to form an educational pipeline with primarily Native American students. The pipeline will involve the students in the geographic area of the seven Tribal Colleges. The grant seeks to increase the number of Native American students graduating from health careers, specifically graduate programs in Psychology.
- HCOP --- This grant has been funded for 3 years and reapplied for funding this year. Funding has not yet been determined for any of the HCOP grants which were recently reviewed.

SAMHSA RESPONSE:
Support for the WINS program will continue beyond FY 2000, contingent on availability of funds.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

IHS RESPONSE:

a. Operates the IHS Scholarship Program (IHSSP), authorized by sections 103 and 104 of the IHCIA. The IHSSP is authorized by two sections of the IHCIA.
    i. Section 103 is the Health Professions Preparatory Scholarship Program for Indians. This section
        a) Helps students to obtain compensatory preprofessional education to help prepare them for a health professional course of study;
        b) Helps pre-medical and pre-dental students to complete the academic requirements for entry into their professional schools; and
        c) Requires no service obligation.
    ii. Section 104 is the Indian Health Professions Scholarship Program. This section
        a) Helps students attend health professions schools (medicine, dentistry, nursing, pharmacy, etc.); and
        b) Requires that students serve an obligation of from 2 to 4 years, depending upon the length of time they receive the scholarship (1-2 years of support require 2 years of service, 3 years require 3 years, and 4 years require 4 years).
    iii. Scholarship recipients must be Indian.
        a) Section 103 scholarships are available to members of federally recognized tribes, members of State recognized tribes, and persons who are descendants in the first or second degree of such members.
        b) Section 104 scholarships are available only to members of federally recognized tribes.

b. Operates the IHS Loan Repayment Program (LRP), authorized by section 108 of the IHCIA.
    i. The purpose of the LRP is to attract and help to retain health professionals at Indian health facilities.
        a) Participants sign a contract that they will serve for 2 years initially, then can extend their contracts one year at a time until their education-related debts are retired.

c. Funds section 102 of the IHCIA, which authorizes the IHS to make grants to public or nonprofit private health or educational entities or Indian tribes or tribal organizations to assist them in
    i. Identifying Indian people "with a potential for education or training in the health professions" and encouraging and assisting them to enroll in courses of study in health professions;
    ii. Assisting Indian people to obtain compensatory education that will help them to qualify for entry into health professions training;

iii. Publicizing information regarding sources of financial assistance available to Indian people enrolled in this program;
iv. Establishing other programs to enhance the enrollment of Indian people in health professions schools.

d. Funds section 110 of the IHCIA, which authorizes grants to Indian health organizations to assist them to establish effective programs for the recruitment and retention of health care professionals.
e. Funds section 112 of the IHCIA, which provides grants to schools of nursing, tribally-controlled community colleges and postsecondary vocational institutions, and nurse midwife and nurse practitioner programs to recruit students to the programs, provide scholarships for them, recruit nurses, nurse midwives, and nurse practitioners to provide health care to Indians, and provide continuing education to nurses, nurse midwives, and nurse practitioners. Scholarship recipients incur service obligations in the same manner as those funded under section 104.
f. Funds section 118 of the IHCIA, which provides a combination work-study program that assists a Licensed Practical/Vocational Nurse or an Associate Degree nurse to obtain a Bachelor's degree in nursing. . Participants incur service obligations in the same manner as those funded under section 104.
g. Funds section 120 of the IHCIA, which provides competitive grant funds to tribes that establish health professional scholarship programs. The grants are competitive. The amount of money available with which to fund them is limited to 5 percent of the funds appropriated for the IHSSP. Scholarship recipients incur service obligations in the same manner as those funded under section 104.
h. Funds section 217 of the IHCIA, which provides grants to 3 colleges and universities for the purpose of developing and maintaining American Indian psychology career recruitment programs. Grantees provide scholarships to Indian students pursuing a career in psychology. Scholarship recipients incur service obligations in the same manner as those funded under section 104.

HRSA RESPONSE:

- NURSING ---- Funding to Projects to Support an Increase in the Number of American Indian Nurses, as follows:

A. TRIBAL COLLEGES AND UNIVERSITIES

Nursing Education Opportunities for Individuals from Disadvantaged Backgrounds / Nursing Workforce Diversity Program These grants meet the costs of special projects to increase the nursing education opportunities for individuals from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among registered nurses) by providing student stipends, preentry preparation, and retention activities. Project WAONSPEKIYA (Project Teach) has as its primary focus to further develop and strengthen support services for the Native American population at Oglala Lakota College Department of Nursing. An important element of this project is the addition of an education specialist who assesses and diagnoses the presence of learning difficulties and special needs of the nursing students. The specialist provides individual counseling and assists faculty in devising approaches to ensure academic success. Faculty engages in periodic review and evaluation of cultural congruency in textbooks, curriculum content, student assignments, and teaching strategies. The development of a Learning Center for Nursing to improve academic performance has proven to be most beneficial.
The network includes Oglala Sioux Tribal leaders; the Porcupine Clinic, a community based independent health care facility; the Pine Ridge School District; and the Oglala
Lakota College science department.

B. NON TCU INSTITUTIONAL FUNDING

Nursing Education Opportunities for Individuals from Disadvantaged Background. Project WAONSPEKIYA (Project Teach) has as its primary focus to further develop and strengthen support services for the Native American population at the University of Alaska Anchorage, Department of Nursing. An important element of this project is the addition of an education specialist who assesses and diagnoses the presence of learning difficulties and special needs of the nursing students. The specialist provides individual counseling and assists faculty in devising approaches to ensure academic success. Faculty engages in periodic review and evaluation of cultural congruency in textbooks, curriculum content, student assignments, and teaching strategies. The development of a Learning Center for Nursing to improve academic performance has proven to be most beneficial. A partnership has been established between the University of Alaska Anchorage, Southeast Alaska Regional Health Consortium, Alaska Federation of Natives, Alaska Native Tribal Health Consortium, and South Central Foundation. The Disadvantaged Students into Nursing project has as its main focus to identify and assist Native American and African American students from disadvantaged backgrounds to successfully enter and complete the associate degree program of nursing. Throughout the matriculation program, participants receive support services, including counseling, mentoring, and the affiliation with professional nursing as an esprit de corps focus. A six-week pre-nursing program assists the students to better prepare for the rigors of earning a nursing degree. The network includes five community colleges located in the rural southeastern North

Carolina region (Fayetteville Technical, Richmond County, Robeson, Sandhills, and Southeastern Community Colleges). The institutions are part of a career ladder strategy, which includes progression into, and successful completion of the UNC-Pembroke RN-to-BSN degree program. Mentors are in place at each community college and all are faculty members in the respective associate degree programs. The main focus of this collaborative effort is to increase the number of American Indian nursing students. The project proposes to develop a supportive network that will continue to nurture and support the nursing students to graduation; and thereby build the pool of BSN prepared nurses who are better prepared to deliver expert care in a rapidly changing practice environment in Montana and the rural West. This project will also increase the number of professional nursing candidates who are qualified to pursue graduate study in advanced practice fields, nursing education, or health care administration. Montana State University at Bozeman has formed a partnership with groups of American Indian nurses, Tribal Community College administrators, HIS officials, and other community stakeholders from the Blackfeet reservation in Northern Montana and on the Crow and Northern Cheyenne reservations in Southeastern Montana. The purpose of this partnership is to develop a support network for American Indian students in pursuit of professional nursing education and practice.

Professional Nurse Traineeships
This program assists eligible institutions to meet the cost of traineeships for individuals in advanced degree nursing programs. Traineeships are awarded to individuals who have completed basic nursing preparation, as defined by the school, through grants to public and nonprofit private entities providing master's and doctoral degree programs to educate individuals to serve in and prepare for practice as nurse practitioners, nurse-midwives, nurse educators, public health nurses, or in other clinical nursing specialties determined by the Secretary of Health and Human Services to require advanced education. The following institutions were awarded traineeships for Native American/Alaska Native nursing students in FY 1999.

Advanced Nurse Education
This grant program prepares nurses in advanced practice as nurse practitioners, nurse-midwives, clinical nurse specialists, nurse anesthetists, public health nurses, nurse educators and nurse administrators through masters and doctoral degree programs, Registered Nurse to Masters degree programs, and post-masters certificate programs in nursing. Institutional programs in this cluster assist eligible entities to meet the costs of projects that support the enhancement of advanced nursing education and practice and traineeships for students in advanced nursing education programs for tuition, books, fees and reasonable living expenses. The following institution was awarded a grant targeting Native American/Alaska Native nursing students in FY 1999.

C. Special Initiatives

- Salish Kootenai College, Pablo, Montana, Satellite Broadcast, Cooperative effort between Office of Minority Health, Division of Nursing, and Tribal Colleges and Universities, December 3,1998, $2,000
- HHS and TCUs Conference and Exposition, Phoenix, Arizona, January 6-8, 1999, Technical Assistance and Consultation by two members Division of Nursing, $1,741.38
- Washington Internships for Native Students (WIN) Summer Internship Program , Support to sponsor an intern in the Division of Nursing Cooperative Agreement with the, American University and American Higher Education Consortium Summer 1999, $ 7,700, Division of Nursing Staff participation at NANA-INA conferences.

Assumptions:

I. The Division of Nursing programs will continue to receive level funding
The Division of Nursing will maintain level funding to TCUs
TCUs will continue to develop successful grant proposals.

I. Nursing Education Opportunities for Individuals from Disadvantaged Backgrounds / Nursing Workforce Diversity Grant Program (CFDA # 93.178A)
These grants meet the costs of special projects to increase the nursing education opportunities for individuals from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among registered nurses) by providing student stipends, preentry preparation, and retention activities. ***There are no grants scheduled for continuation funding in FY 2001. There are two TCU nursing programs that have submitted applications for funding beginning in FY2000. One of the applications is a well-developed project requesting approximately $180,000 in FY2001.***

II. Basic Nurse Education and Practice Grant Program (CFDA# 93.359A)
This grant program enhances the educational mix and utilization of the basic nursing workforce by strengthening programs that provide basic nurse education such as: establishing expanding nursing practice arrangements in noninstitutional settings to improve access to primary health care in medically underserved areas; providing care for underserved populations; providing

managed career, quality improvement, or other skills needed to practice in existing and emerging organized health care systems; developing cultural competencies; expanding the enrollment in baccalaureate nursing programs; promoting career mobility in a variety of training settings; providing education in informatics, including distance learning methodologies.

There are no grant applications scheduled for continuation funding in FY 2001 and there are no new applications submitted for this funding period.

III. The Advanced Education Nursing Cluster (CFDA # 93.299A)

This grant program prepares nurses in advanced practice as nurse practitioners, nurse-midwives, clinical nurse specialists, nurse anesthetists, public health nurses, nurse educators and nurse administrators through master's and doctoral degree programs, Registered Nurse to Master's degree programs, and post-master's certificate programs in nursing. Institutional programs in this cluster assist eligible entities to meet the costs of projects that support the enhancement of advanced nursing education and practice and traineeships for students in advanced nursing education programs for tuition, books, fees and reasonable living expenses.

(There are no TCUs with graduate nursing programs at this time.)

- ALLIED HEALTH: Same as #2 above.
- MEDICINE/DENTISTRY ---- For 2001, HRSA will continue to explore avenues to assist Tribal Colleges and Universities (TCUs) in applications for Physician Assistant grants. HRSA will continue its working relationships with key officials in TCUs to encourage American Indian/Alaska Natives to pursue careers in the health professions.
- PSYCHOLOGY ---- HRSA has adopted a special initiative to increase the number of American Indian health care providers especially in the area of behavioral mental health. This initiative follows the Executive Order 13201 of October 19, 1996 "Tribal Colleges and Universities" which promotes the access of high quality educational opportunities for economically disadvantaged students and explores innovative approaches to better link Tribal Colleges with early childhood, elementary and secondary education programs. There are three major aspects in the implementation this initiative. The first project is a purchase order with the University of Montana (UM) Department of Psychology to develop four nationally acceptable behavioral mental health-training modules. The second is a Health Careers Opportunity Program (HCOP) grant with the UM Department of Psychology incorporating programming at the seven Tribal Colleges in Montana. And, the third is the commitment of HRSA to incorporate or link Distance Learning into the educational framework for the Native American population. The UM submitted an unsolicited proposal to establish a culturally relevant, academically based, behavioral mental health program. This program initiates a Native American educational pipeline. The goal is to increase the number of Native American students from the seven Tribal Colleges in Montana who choose psychology early in their preparation for a health professions career. The UM will establish behavioral mental health training modules for the seven Tribal Colleges in Montana and link these programs to the UM graduate programs in psychology. In the fall of 1999 the UM and the seven Tribal Colleges in Montana organized a consortium to work together in the development and implementation of behavioral mental health modules throughout their respective institutions. The consortium agreed to develop modules in the following four psychological subfields: Abnormal Psychology, Psychology of Personality, Social Psychology and Psychological Research Methods. All four modules were completed in January 2000. All seven Tribal Colleges received two modules in January 2000. Five of the Tribal Colleges implemented at least one of the modules into their curriculum this spring; the remaining two are planning to implement at least one module in summer 2000.
- HCOP --- HRSA funds a Health Career Opportunities Program (HCOP) grant for the Association of American Indian Physicians (AAIP). The AAIP will develop a national network of resources to identify and support the recruitment and retention of American Indian students in the health professions by increasing the involvement of tribes, schools, and health professions programs at the local level. AAIP will identify and additional 200 students using the network. Site visits and presentations will be given on reservations. A tracking system (data base) will be established of students interested in the health professions and information about health careers will be provided. The AAIP, HCOP offers the following opportunities to interested students. They will receive information regarding summer programs, student opportunities and financial aid. AAIP/HCOP participants will also be included in the AAIP Pre-Admission Workshop which helps prepare students in the process of admission into a medical school. Ten students, a year, will be allowed to participate in the AAIP summer Live-In program, in which students spend 4-7 days with an AAIP physician. The students will also be involved in the Mentoring Program. This program assists the students in their transition from the reservation/rural/tribal communities to health profession school. The Mentor will provide an inside track to the student who express the desire to pursue a health career.

SAMHSA RESPONSE: SAMHSA's Office of Minority Health has supported the "WINS" program (Washington [DC] Internship for Native Students) since FY 1998. The program funds summer internship placements of AI/AN students enrolled

in TCUs. TCUs train providers of substance abuse and behavioral health services and make telemedicine services/capacity available with the goal of enhancing clinical training and supervision in order to redress rural problems with scarcity of psychiatrists and licensed providers.

4. **Appropriations information related to the issue/issue area (FY00, FY 01):**

IHS RESPONSE:

a. FY 2000 appropriation: $30,491,000 (combined Scholarship and Loan Repayment Programs)
b. FY 2001 request: $32,779,000, House recommendation: $30,491,000 (combined Scholarship and Loan Repayment Programs)

HRSA RESPONSE:

- NURSING ---- FY 2000 funding in process. See attached report entitled FY 2001 estimate for TCUs.
- ALLIED HEALTH --- $10,000 $ 180,000
- MEDICINE/DENTISTRY --- N/A
- PSYCHOLOGY--- Through a contract mechanism, $99,000 was awarded to this project in FY '99. An HCOP grant application has been received from the University of Montana, but has not yet been awarded. Funding options for FY01 are being explored for implementing the distance-based learning proposal.
- HCOP --- Funded at $ 139,000 level for FY 00. Applied for funding in the amount of $ 250,000 for FY01.

SAMHSA RESPONSE: FY 2000 - $8,000

5. **Obstacles to address issue/issue area:**

IHS RESPONSE: The primary obstacle to maximizing the impact of all of the programs described above is a lack of funds. We have been able to fund only 15 percent of the scholarship applicants and less than 1/2 of the loan repayment applicants for the past several years.

HRSA RESPONSE:

- NURSING ---- Note comments in summaries that identify specific strategies to address needs of students.
- ALLIED HEALTH ---- Getting people to be aware of the Allied health special project grants and writing competitive and appropriate grant applications
- MEDICINE/DENTISTRY--- Lack of knowledge of TCUs in interacting with the Division of Medicine and Dentistry and applying for HRSA grants. ISTRY ----
- PSYCHOLOGY --- Distance and funding.
- HCOP --- Needs approval for funding.

SAMHSA RESPONSE: N/A

6. **Strategies to overcome obstacles:**

IHS RESPONSE: The Congress has, for the past 2 years allowed the IHS to spend up to $17million on the Loan Repayment Program (over the $11 million appropriated) and the IHS has used this as a means to allow the Areas to contribute amounts to meet local staffing priorities (while adhering to established national health professions priorities).

HRSA RESPONSE:

- NURSING -- See #2 above.
- ALLIED HEALTH: Provide technical assistance. Send letters about the grants to TCU presidents
- MEDICINE/DENTISTRY – See #3 above
- PSYCHOLOGY ---- It is the goal of HRSA to assist the UM, and the seven Tribal Colleges throughout the state, in linking their educational resources through distance learning. To accomplish this goal, HRSA will strengthen the relationship it has formed with the UM and the Tribal Colleges and assist in the development of Distance Learning in the health professions (specifically in behavioral mental health). Technical assistance has been provided to the University of Montana. Although an HCOP grant application has been received, it is uncertain yet whether it will be funded.
- HCOP --- None

SAMHSA RESPONSE: N/A

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: Darrell Pratt Leader, Health Professions Support Team, Office of Management Support, Indian Health Service, 301-443-4242

HRSA RESPONSE:

- NURSING ---- Barbara Easterling MS RN, Nurse Consultant, 301 443-8798.
- ALLIED HEALTH ---- Dr. Norman Clark,Chief of Allied Health and Other Professions Branch, (301)443-1346
  Young Song, Allied Health Program Officer, x31346
- MEDICINE/DENTISTRY -- Florence Foss, Program Analyst, 301-443-8647
- PSYCHOLOGY -- Dan Reed, Project Officer, Division of Disadvantaged Assistance, 301-443-2982.
- Dan Reed, Project Officer, Bureau of Health Professions, Division of Disadvantaged Assistance, 301-443-2982.

SAMHSA RESPONSE: Steve Sawmelle , Intergovernmental Coordinator , Office of Policy and Program Coordination(301) 443-0419.

SECTION III: CARE PROVIDERS

#2		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Some providers lack appropriate credentials	Assist with licensing of dentists and doctors that have licensure in another state. Assist tribes to access training and continuing education for physicians and staff (i.e., federal/non-federal resources and programs.)	IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issue area:**
IHS RESPONSE: There is little the IHS can do in the matter of licensure/certification other than advocate for the applicant as licensure is between the state of jurisdiction, the employing tribe, and the individual provider. Certification is between the provider and the certifying body.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE:

a. Advocate for applicants who need licenses in the states in which they will be working.
   i. Assist applicants to learn the licensure requirements of the facilities to which they are applying.
   ii. Assist facilities to know their state licensure requirements so they can also assist new applicants.
   iii. Assist applicants to contact appropriate state licensing board.
b. Tribal staff members are invited to IHS-provided continuing medical education training.
c. The IHS has established a policy that facilities may purchase second licenses for physicians whose duties require that they obtain staff privileges in non-IHS facilities in order to perform their jobs effectively (e.g., the physician is assigned to a health center, which has no inpatient capabilities, but is required to obtain staff privileges at a local hospital in order to admit IHS patients there and the hospital requires that he/she be licensed in the state in which it is located and the physician's license that qualifies him/her for federal employment is in another state).

4. **Appropriations information related to the issue/issue area (FY00, FY 01):**
IHS RESPONSE:
Not applicable

5. **Obstacles to address issue/issue area:**
IHS RESPONSE:
   a. States are the licensing authorities and requirements can vary from one to another.
   b. There are separate certifying bodies for each profession. Obtaining certification through them usually requires that a professional sit and pass an examination.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: As noted above, licensure and certification are matters between the state, the certifying body, the tribe, and the applicant. There is little, if anything, the federal government can do to impact this process.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: Darrell Pratt, Leader, Health Professions Support Team, Office of Management Support, Indian Health Service, 301-443-4242

SECTION IV: FACILITIES, EQUIPMENT AND SUPPLIES

#1		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Lack of Facilities: • Health care • Chemical dependency programs • Renal dialysis units/clinics • Nursing home facilities • Emergency rooms	• Assist tribes to find alternate means for constructing needed facilities • Upgrade emergency rooms	AOA IHS HCFA HRSA SAMHSA

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

AOA RESPONSE: N/A

HCFA RESPONSE: Refer to issues #3

HRSA RESPONSE: N/A

SAMHSA RESPONSE: NOTE: CSAT provides service funds for substance abuse treatment through the Substance Abuse Prevention and Treatment (SAPT) Block Grant. These funds may not be used for construction of facilities for such programs, although rental and other facility overhead costs may be reimbursable expenses, in accord with state procedures and policies.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The IHS will continue to advocate for joint venture funding and small ambulatory grants, which are authorized under P.L. 94-437. Additionally, the IHS will continue to identify and inform tribes of options available for innovative tribal financing for health care facility construction.

AOA RESPONSE: AoA has developed a grant resource manual specific for American Indian, Alaska Native and Native Hawaiian funding opportunities from government agencies, private/non-profit foundations, etc. A copy of the manual has been provided to each grantee. Training on finding and applying for grants will be included in national and regional conferences.

HCFA RESPONSE: Refer to issues #3

3. OPDIV/STAFFDIV activities to date on this issue/issue area:
IHS RESPONSE: The *Report of Roundtable Discussion and Analysis of Future Options for Indian Health Care Facility Funding*, as sponsored by the IHS at the U.S. House of Representatives Office Building on August 17 and 18, 1999, is being provided to all interested tribes, as an aid in determining alternate means for funding facilities construction. Using Medicare/ Medicaid funds, the IHS is addressing through renovation and expansion projects the need to upgrade emergency rooms in IHS health care facilities. Also, as replacement projects are being processed in the IHS Health Facilities Construction Priority System, the new health care facilities include upgraded emergency rooms.

AOA RESPONSE: AoA plans to update the manual, as needed, and to have ongoing discussions with Tribes at workshops, conferences, and private meetings concerning funding opportunities.

HCFA RESPONSE: Refer to issues #3

4. Appropriations information related to the issue/issue area (FY00, FY01):
IHS RESPONSE: Annual facilities construction funding needs are identified in the IHS Five-Year Plan, and funds are appropriated by the Congress, as funding priorities allow.

AOA RESPONSE: N/A

HCFA RESPONSE: Refer to issues #3

5. Obstacles to addressing issue/issue area:
IHS RESPONSE: Funding constraints and other priorities have precluded complete funding to date.

AOA RESPONSE: Few resources are available.

HCFA RESPONSE: Refer to issues #3 and #23

6. Strategies to overcome obstacles:
IHS RESPONSE: (a) The IHS will continue to seek the identification of alternative funding for tribal health care facilities construction projects. (b) The IHS is planning to convene a tribal committee that will make recommendations for establishing a new health care facility construction priority list. (c) The IHS has been working with the P.L. 94-437 Steering Committee to incorporate provisions in the tribal mark-up that would enhance alternative financing of health care facilities.

AOA RESPONSE: AoA will continue to seek information on available resources and provide this information to the Title VI grantees. Additionally, the National Resource Centers on American Indian Aging are available to provide assistance in writing grant proposals.

HCFA RESPONSE: Refer to issues #3 and #23

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
IHS RESPONSE: Jose F. Cuzme, P.E., Chief, Facilities Engineering Branch, Division of Facilities and Environmental Engineering, Office of Public Health, Indian Health Service,
301-443-1850

AOA RESPONSE: M. Yvonne Jackson, Director, OAIANNHP, (202) 619-2713

HCFA RESPONSE: Refer to issues #3

SECTION IV: FACILITIES, EQUIPMENT AND SUPPLIES

#2		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Ability of facilities to meet JCAHO standards (facilities cannot compete with non-tribal facilities for patients).		HCFA IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

HCFA RESPONSE: 42 CFR 488.4 to 488.11 describes the application and reapplication procedures for accreditation organizations. A national accreditation organization, such as the Joint Commission on Accreditation of Health Organizations (JCAHO), who applies for approval of deeming authority for Medicare requirements must furnish to HCFA the information and materials specified in this section.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The Environmental Health Services Branch provides highly skilled personnel to assist clinical staff in meeting JCAHO accreditation standards through its Institutional Environmental Health program.

HCFA RESPONSE: The Survey and Certification Group in CMSO proposes a two tiered approach to the issue that tribally-owned facilities lack sufficient capital to become accredited. We propose that HCFA recommend to the Joint Commission that accreditation fees for tribally-owned facilities be waived or offered at a reduced rate. Failing that step, we further recommend that tribal facilities be incorporated into the same rate setting process that the Indian Health Service currently enjoys with the JCAHO.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: Since 1980, the IHS has supported a postgraduate training program in institutional environmental health. The purpose of the postgraduate program is to ensure a cadre of highly trained specialist that will enable IHS and tribal health care facilities with all applicable regulatory guidelines and standards. Since 1980 a total of 19 individuals have completed this program. In addition to the postgraduate program, the IHS provides a variety of short courses that are designed to provide local collateral duty safety and infection control officers with the knowledge that they need to effectively perform their duties. Currently 100% of IHS operated hospitals and health centers are accredited by JCAHO or equivalent accrediting body.

HCFA RESPONSE: HCFA is establishing a workgroup to determine possible changes in surveying tribal facilities. This workgroup will determine the ramifications of implementing the option, which provides that the ROs survey all Tribally owned and operated facilities. The issues to be studied should include, among others, the number of facilities affected, the impact of this option on RO workloads and staff, State licensure and certification costs, use of national survey teams, use of joint teams comprised of RO and State agency staff and alternatives.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: There have never been any direct appropriations to the IHS budget to support this activity. However the Division of Facilities and Environmental Engineering provides approximately $100,000 per year from the Facilities and Environmental Health Support Account to support institutional environmental health training activities.

HCFA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: Currently only 7 Areas (Bemidji, Billings, California, Oklahoma and Tucson are the exceptions) have full time Institutional Environmental Health Specialists on staff to address JCAHO and other regulatory issues. Furthermore regulatory standards that have been promulgated by the EPA, OSHA, JCAHO and others are becoming increasingly complex, and collateral duty safety and infection officers are finding it increasingly difficult to keep abreast of changing requirements. Currently very few IHS and tribal inpatient health care facilities are provided with full time safety and infection control officers to meet the increasing demands.

HCFA RESPONSE: The extra costs involved in the additional workload on the Regional Office staff will need to be studied by the workgroup.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: Environmental Health and Engineering staff are working with local health care facility administrators to seek funding from Medicare/Medicaid reimbursements to fund full time safety and infection control officers in each inpatient facility.

HCFA RESPONSE: The creativity of the HCFA workgroup may provide an alternative solution to this issue. The answer to this issue is believed to require a long-term period over 12 months to provide answers.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: W. Craig Vanderwagen, M.D.. Director, Division of Clinical and Preventive Services, Office of Public Health, Indian Health Service, (301) 443-4644

HCFA RESPONSE: Mary Weakland (Nurse Consultant – HCFA) – (410) 786-6835

SECTION IV: FACILITIES, EQUIPMENT AND SUPPLIES

#3		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Inadequate facilities construction process (new construction, replacement and renovation):	Identifying, prioritizing, and/or justifying new construction and replacement is time consuming and not working. (i.e., Parker Hospital). Facility construction issues affect number of medical staff, equipment, supplies, and auxiliary providers. Delay in new construction also delays funding to bridge gap between existing services and services required to meet present and future demands.	IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The IHS is considering how best to address the concern expressed by the Tribes and the Congress in the 2000 Conference Report Language (106-479).

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: In fiscal year 2000, with tribal participation, the IHS is working towards improving the current IHS Health Facilities Construction Priority System Methodology. This request is consistent with the desires of the tribes based on their proposed mark-up of Public Law 94-437, which is up for reauthorization. The tribal consultation process with this issue is expected to take considerable time.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: No specific funding has been appropriated for this issue.

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: The issue is complex and requires extensive tribal consultation, which is planned.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: The issue is complex and requires extensive tribal consultation, which is planned.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: Jose F. Cuzme, P.E., Chief, Facilities Engineering Branch, Division of Facilities and Environmental Engineering, Office of Public Health, Indian Health Service
301-443-1850

SECTION IV: FACILITIES, EQUIPMENT AND SUPPLIES

#4		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Equipment: Need for disaster preparedness and disaster response equipment (i.e., backboards, radios, jaws of life, etc.)		HRSA IHS OPHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

OPHS RESPONSE: Robert T. Stafford Disaster Relief and Emergency Assistance Act, as amended (41 U.S.C. Sec. 5121, et seq); PHS Act, 42 U.S.C. 319; Executive Order 12656, November 18, 1988; Executive Order 12919, June 6, 1994; 55 FR 2879, Office of the Secretary; Statement of Organizations, Functions, and Delegations of Authority, January 29, 1990

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: Environmental health services staff continues to seek new funding in fiscal years 2001 and beyond to continue to provide one time funding to tribes and tribal organizations to purchase emergency response equipment that has been proven to be effective in reducing the severity of motor vehicle related injuries.

OPHS RESPONSE: During Presidentially declared disasters or major emergencies, health and medical response assets, with appropriate medical equipment, is furnished through Emergency Support Function #8 (Health and Medical Services) of the Federal Response Plan, by activation and use of the National Disaster Medical System. The NDMS will continue to response to emergency situations which occur on Indian reservations.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: Since fiscal year 1990, approximately $2,000,000 has been provided to tribes and tribal organizations to fund injury prevention projects. Several of these projects have been used to purchase EMS type equipment.

OPHS RESPONSE: OEP has provided funding to enhance the capabilities of the NDMS response teams, . including necessary equipment for at least the past three years. This added capability will increase the NDMS ability to response to emergency situations on Indian reservations.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: $1,475,000 was appropriated in the FY00 budget for injury prevention. Of this total, approximately $300,000 has been identified to fund additional community-based injury prevention interventions.

OPHS RESPONSE: $4.0 million of appropriations for OEP has been utilized for the logistical enhancement of NDMS response teams in FY 2000. $4.1 million has been earmarked for FY 2001. No specific amount of these funds are allocated for specific populations. The OEP will continue to response to all emergency disasters that affect residents of the United States. $4.0 million of appropriations for OEP has been utilized for the logistical enhancement of NDMS response teams in FY 2000. $4.1 million has been earmarked for FY 2001. No specific amount of these funds are allocated for specific populations. The OEP will continue to response to all emergency disasters that affect residents of the United States.

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: The funds identified for injury prevention initiatives represent approximately one-half of the total amount needed to adequately address the problem. Specific to disaster preparedness and response equipment the IHS has purchased a limited amount of equipment for disaster teams. This equipment consists of small field kits for testing such things as water, air quality, etc. and equipment to setup field bivouacs. There are two agencies the IHS partners with on a regular basis, specifically to provide medical direction, training and credentialing: HRSA's Maternal Child Health Bureau and the National Highway Traffic Safety Administration.

OPHS RESPONSE: N/A

6. **Strategies to overcome obstacles:**
IHS RESPONSE: The funds identified for injury prevention initiatives represent approximately one-half of the total amounts needed to adequately address the problem. IHS continues to seek new funding.

OPHS RESPONSE: N/A

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: David Wallace, Acting Principal Injury Prevention Consultant, Indian Health Service, (770) 488-4712

OPHS RESPONSE: Bob Jevec, OSOPHS/OEP, 301-443-5708.

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

#1		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Opportunities for Partnership	Partnerships: • Explore new and creative approaches (partnerships) for efficient delivery of services for tribes. • Encourage collaboration between state and tribal governments. • Assist in helping private businesses become partners with tribes.	All OPDIVs/STAFFDIVs

1. Public Law(s) or authorization related to this issue/issue area:
IHS RESPONSE: N/A

ACF RESPONSE:
- Title IV-D of the Social Security Act (Child Support Enforcement - CSE)
- Section 639 of the Head Start Act, as amended. Head Start Performance Standards 1304.41 specifically requires Head Start (HS) and Early Head Start (EHS) programs to establish and maintain on-going collaborative relationships with community organizations, local educational agencies, cultural institutions, child care providers, and any other businesses and community organizations that may provide support or resources to families.
- TANF – Temporary Assistance to Needy Families –Section 412 of the Social Security Act
- CCB – Child Care and Development Block Grant Act of 1990 (Section 5082 of the Omnibus Budget Reconciliation Act of 1990, Public Law 101-508, as amended).
- Native American Programs Act of 1974, as amended. (ANA)

AOA RESPONSE: N/A

HCFA RESPONSE: The President's Executive Memorandum of April 29, 1994 encourages Federal agencies to consult, to the extent practicable, with Tribal governments on issues that affect them. Executive Order 163084 encourages regular and meaningful consultation and collaboration with Tribal governments. Section 1115 of the Act permits States to test innovative programs under the Medicaid program.

AHRQ RESPONSE: N/A

CDC RESPONSE: Of the items listed above under "Tribal Recommendations," CDC contributes to the collaboration between state and tribal governments. Many CDC-sponsored projects and programs depend upon effective collaboration between state and tribal governments. Public Health Service Act, particularly Title III, General Powers and Duties of the Public Health Service; 25 USC 18, Subchapter II, Section 1621m.

HRSA RESPONSE: MCH Title V of the Social Security Act. Healthy Start (Sec. 301, PHS Act).

IGA RESPONSE: N/A

SAMHSA RESPONSE: 42 USC 300x , 42 USC 290aa, 42 USC 290ff

FDA RESPONSE: Public Health Service Act, Chap. 288—37 Stat. 309 (1912), 42 U.S.C., subsection 201 et. seq.

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:
IHS RESPONSE: Although HHS could pursue this issue internally, it does not make sense to do so without the benefit of tribal leadership. Therefore, HHS should charge a sub-group of the HHS Interagency Tribal Consultation Workgroup to meet with tribal leaders and/or their representatives to discuss/explore this issue and the potential partnering that could also be developed with private entities. As appropriate, State government officials could also be called upon to join the group to explore what enhanced collaboration the tribes, HHS and States could pursue.

ACF RESPONSE:

- CSE

Under Section 455(f) of the Social Security Act the Office of Child Support Enforcement (OCSE) will be providing direct Federal funding to Indian Tribes and Tribal organizations to operate their own Tribal CSE programs/agencies.
CSE cooperative agreements between States and Indian Tribes/Tribal Organizations are facilitated by section 454(33) of the Social Security Act.

- ANA

ANA will continue to form partnerships and make other arrangements (special initiatives, inter-agency agreements) to increase collaboration and improve service delivery. One such collaboration involves working with the Office of Community services in ACF to work on pilot sites that are targeted to economic development strategic planning and implementation as an approach in addressing welfare reform.

- CCB

CCB will continue to provide technical assistance to its 257 Tribal grantees on program implementation service delivery issues through a specialized tribal contract with an 8(a) Native American owned-firm.

AOA RESPONSE: AoA will encourage the Title VI program to increase their coordination and collaboration with other local programs by providing workshops, sharing of best practices, conducting joint meetings, etc. The AoA Central Office will continue to work with other agencies, such as HCFA, IHS, Social Security, VA, and USDA, to enhance ongoing partnerships for efficient delivery of services. The AoA Regional Offices will enhance their activities to promote Tribal and State coordination.

HCFA RESPONSE: HCFA will continue to work in partnership with the States and Tribes through the consultation process or other methods to provide information and technical assistance for improving the delivery of services to AI/An beneficiaries under Medicaid, Medicaid, and SCHIP.

AHRQ RESPONSE: In a planned June 2000 User Liaison Program Workshop, AHRQ will explore the subject of innovative partnerships and the relationship between states and tribes; many tribal representatives and staff of other multi-tribal groups will be participating. Also, tribes wanting to conduct research on this subject area can submit grant applications under AHRQ's "Program Announcement," which lists the agency's broad areas of research interest.

CDC RESPONSE: Engage state health departments and CSTE (Council of State and Territorial Epidemiologists) in the planning and development of surveillance systems for AI/AN communities, including urban populations; Encourage AI/AN governmental participation in CSTE; Assist tribes, tribal coalitions, Alaska Native corporations, IHS, and state health departments in the development of data sharing agreements; Work with AI/AN governments and state governments to develop model public health codes;

HRSA RESPONSE: None

IGA RESPONSE: IGA, along with OPDIVs, will work with National Conference of State Legislatures and National Governors Association, National Association of Counties, and U.S. Conference of Mayors to formulate tribal/state partnerships and collaboration between state and tribal governments to explore new and creative approaches for efficient delivery of services for tribes.

SAMHSA RESPONSE: SAMHSA will continue to offer grants for capacity building, knowledge development, and systems change, as well as providing technical assistance to help tribal communities qualify as state sub-recipients.

FDA RESPONSE: FDA is developing a system that would identify projects suitable for collaborative action; find appropriate partners to share FDA's interest in performing the necessary work, combining FDA's and the partner's efforts toward reaching mutual public health objectives. FDA intends to expand current efforts and seeks to develop new partnerships. FDA welcomes ideas and opportunities to further develop capabilities.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

IHS RESPONSE: In Dr. Trujillo's 1994 Senate confirmation hearings, he stressed that the IHS alone cannot improve the health status of Indian people without mutually beneficial partnerships. Addressing the health needs of AI/ANs requires the strengthening of existing partnerships among tribal nations, urban Indian health organizations, academic medical centers and

universities, and business and professional organizations. The IHS has sponsored numerous opportunities for tribal governments to interact with academic medical centers and universities as well as foundations. The highlight of this type of activity has been the sponsorship of 2 major national conferences in June 1998 and December 1999 that provided the opportunity for close interaction on issues of critical importance to Indian country and networking. A major result of this effort is the proposed establishment of tribally controlled research centers with academic partnerships sharing the responsibility of training AI/AN in research by conducting clinical/behavioral/biomedical research that has tribal government approval.

ACF RESPONSE:

- CSE

Tribal consultations were conducted across Indian Country to get tribal input on CSE regulations and policies. The Tribal Direct Funding NPRM is to be published soon. It is ACF's intention that this publication will facilitate efficient delivery services to Tribes through direct funding to Tribes.

- HS

Indian Head Start works collaboratively with the Child Care Bureau, Children's Bureau, TANF, and ANA in ACF. Agreements are in place with the IHS/PHS, Office of Security/BIA and the Office of Indian Housing/HUD. In FY 2000, HS funded seven tribal colleges for a variety of model early education programs. It is anticipated that an additional eight tribal colleges to train Head Start staff, parents and teachers will be funded.

- TANF

The importance of States and Tribes establishing effective coordination and linkages has had continual emphasis from ACF Central and Regional Offices, as well as with Native American organizations. Such linkages are essential to insure that support and work services, training, and placement opportunities are provided to TANF participants that best help move them from welfare to work, as well as the exchange of necessary program information. Discussion between the Division of Tribal Services (DTS) has been and continues with ACF Regional Offices concerning the Tribal TANF and Native Employment Works (NEW) programs, with States wherein Tribal TANF programs are operable or program planning is being considered.

The DTS has made presentations at conferences held by the National Congress of American Indians, Washington University School of Social Work, and the National Association of Social Work. Briefings have been conducted for the U.S. Senate Committee on Indian Affairs as well. In FY 2000 the DTS participated at three ACF wide Tribal Forums entitled "Empowering Indian Families in the New Millennium". The conference goals were to enhance the understanding of the broad range of ACF programs and to introduce the Tribal TANF regulations. Federal and State officials were invited to collaborate and dialog with tribal officials throughout the forums. In addition, ACF has published a Tribal Resource Directory of ACF Programs to provide useful information for Tribes on ACF programs that benefit Tribes and the Native American service population. This directory and other information on these programs is also available through the ACF tribal resource web site – www.acf.HHS.gov/programs/ana/council.htm. ACF is hopeful that the directory and website will encourage Tribes to use ACF-wide programs as they look at creative approaches for efficient service delivery.

- CCB

Each year CCB invites Tribes to its annual meeting of State Child Care Administrators. At this meeting, a workshop is always held with a tribal representative and a state representative to discuss State-Tribal collaboration activities. In addition, State Lead Agencies are invited to attend the annual Tribal Child Care Conference. Seven (7) State Lead Agency representatives from 4 States attended the 2000 tribal conference in Portland, Oregon in May 2000.

- ANA

ANA Social and Economic Development Strategies (SEDS) grants have continually funded economic development projects where Tribes are partnering or teaming with businesses. ANA also collaborates with most of the federal Departments including Education, Commerce, Housing and Urban Development, Energy, Agriculture, Interior (BIA and NPS) and Labor addressing such varied issues as economic development, social conditions, cultural preservation and new and emerging issues such as energy development. ANA through its grant programs and inter-agency involvement strives to explore innovative approaches to address issues and to leverage other federal funding.

AOA RESPONSE: See response to #2 above.

HCFA RESPONSE: HCFA has developed and continues to seek Tribal input to further improve our consultation policy statement, which encourages collaboration between States, Tribes and the Federal government. Consultation meetings were held by all HCFA Regional Offices during 1999, and we are continuing to actively consult with Tribes and States on ongoing and emerging issues. We are also working in partnership with IHS and the national Indian Health Board to identify key areas in

which tribes require technical assistance so that we may better target our efforts to meet their needs. HCFA continues to encourage States to include Tribes in the development of innovative service delivery systems under Medicaid. This is done, for example, by requiring States to demonstrate how Tribes were consulted in developing section 1115 demonstration proposals. In addition our consultation and technical assistance efforts, we have initiated other activities, one of which involves the Peer Review Organization program. This program, created by the TAX Equity and Fiscal Responsibility Act (P.L. 97-248), was designed to ensure that quality care is provided under the Medicare program. The Sixth scope of work (SOW) contract with PROs emphasizes achieving improvement through partnerships with health plans, practitioners, providers, state agencies, other purchasers, and consumers. Under Task 2.b.2 of the SOW, each PRO must develop a project designed to reduce the disparity of care received by members of disadvantaged groups and all other beneficiaries in the PROS's State. The disadvantaged groups include Native Americans. The Utah PRO (HealthInsight) has elected to pursue a project to increase influenza and pneumonia immunizations among American Indians and Alaska Natives. The Utah PRO is expected to pursue this project in partnership with all agencies with the State working with the target populations, including D.R.E.A.M.M. Grant Coordinators (Developing Reservation-based Efforts Addressing Meortality and Morbidity); the Utah Department of Health, Tribal Liaison; Health, Office of Ethnic Health; the Utah Department of Aging Services; and the Community Health Clinics of Utah. In a separate activity, the Utah PRO is partnering with the State to identify American Indians who are Medicare eligible and encourage program enrollment.

AHRQ RESPONSE: While not directly, involved in researching creative approaches (partnerships) for efficient delivery of services for tribes, AHRQ has pursued creative approaches (partnerships) with other organizations in its approach to conducting health services research in Indian country. For instance, AHRQ has an ongoing dialogue with IHS on how it can help support IHS' research function, has engaged in discussions with NIH about teaming up to support tribally-sponsored research in Indian country, and has discussed with the Association of American Indian Physicians how it can help support the planned August conference on improving the quality of health care in Indian country.

CDC RESPONSE: anticipated in round table discussions on AI/AN health/surveillance issues at annual CSTE meeting (1999);

- Assisted Navajo Nation in developing strong partnerships with the state health departments of AZ, NM, and UT to address a variety of infectious disease threats, including hantavirus disease and plague;
- Assisted ITCA (InterTribal Council of Arizona) in the development of data sharing agreements;
- Assisted IHS in the development of partnerships between the MN Dept. Of Health, the SD Dept. Of Health, and tribal communities in the Bemidji and Aberdeen Areas to address disease due to MRSA (methicillin-resistant *Staphylococcus aureus*);
- Consulted with the Maine Bureau of Health in its efforts to assist Maine tribes in conducting community health status assessments;
- Assisted IHS, tribal governments, and the MT Dept. Of Health in the investigation of hepatitis B disease in Montana;
- Developed a Ramah Navajo Chapter-IHS-CDC-NM Dept. Of Health partnership to implement a project to reduce exposure to rodents in the homes of Ramah Navajo residents;
- Worked in partnership with the Yukon-Kuskokwim Health Corporation and the Alaska State Health Department (and others) to investigate iron deficiency anemia in Alaska Native children;
- Two state health departments (OK and MN) are recipients of CDC REACH grants that focus on AI/AN populations; Provided funding within the state-targeted Preventive Health and Health Services Block Grant to the Santee Sioux and Kickapoo tribes for chronic disease prevention activities;
- In 1998 and 1999, CDC funded the first and second annual *Common Ground* conferences to increase HIV prevention activity by forming collaborations between State Departments of Education and AI/AN communities;

HRSA RESPONSE (MCH):

Healthy Start:			
Northern Plains Healthy Start	Aberdeen Area Tribal Chairman's Health Board	Aberdeen, SD	$2,419,760
Maajtaag Mnobmaabzid (A Start of a Healthy Life)	Inter-Tribal Council of Michigan	Sault Ste. Marie, MI	$771,533
Honoring Our Children With a Healthy Start	Great Lakes Inter-Tribal Council	Lac du Flambeau, WI	$1,427,725
CHIP:			
Puentes Program (Taos Teen	Presbyterian Medical	Santa Fe, NM	Extension

Parent Support Program)			
Helping Indian Children Of Albuquerque	All Indian Pueblo Council, Inc.	Albuquerque, NM	Extension

SAMHSA RESPONSE: Grants to improve the systems of care in the *Child Mental Health Initiative* require matching funds. The *Circles of Care* grants require a survey of the entire system of care, and both grant programs encourage strategic planning between state and tribal systems of care. The *Community Action Grants* seek to improve relationships between providers, and to develop new and creative approaches. CSAP's largest capacity-building grant program is the State Incentive Cooperative Agreement program, in which the money is awarded to a state that successfully competes in a peer-review grant process. Under this program, states must award 85 percent of the funds to subrecipient communities to implement new or expanded prevention programs that employ the best prevention practices. There are 21 states which have been awarded funding through this program; four more states are expected to be funded this summer. Seven states have made subrecipient awards to over 40 American Indian and Alaska Native programs. Subrecipient grants range from $80,000 to $150,000. In a collaborative effort, IHS has agreed to detail two people to SAMHSA, each at half time, to CSAP and CSAT. One person began work at the end of March 2000, and the other will begin at the end of June. The IHS staff will be closely involved with SAMHSA's work with American Indians/Alaska Natives

FDA RESPONSE: OPDIV/STAFFDIV activities to date on this issue/issue area: The nation is faced with emerging new diseases, global markets, shifting demographics, and rapidly evolving technologies. While the Food and Drug Administration's (FDA) mission is to protect the public health, academia, health providers, other government entities, regulated industry, and consumers also have a role. Historically, FDA has expanded its use of outside advisory committees to harness the intellectual capabilities of others to assist in product reviews; and created its first government/academia/industry collaboration to provide scientific information and expertise in food processing and packaging technologies to protect and enhance the safety of food. Other established partnerships include: (1) a multidisciplinary research and education partnership with the University of Maryland working in areas of risk analysis, applied nutrition, microbial pathogens and toxins, and animal health sciences; (2) Mammography Quality Standards Act-MQSA Program working with private and sate accreditation bodies to ensure that mammography facilities meet the quality standards FDA has developed; (3) conducting research to support sciences-based regulatory policy regarding product quality information through the Center for Drug Evaluation and Research's Product Quality Research Institute (PQRI); FDA's National Center for Toxicological Research has developed programs with other government agencies, industry and academia to foster collaboration and leverage outside scientific expertise – including risk assessment research projects, bioassays involving toxicity of FDA regulated products, and using DNA microarray technology to identify subpopulations at higher risk for adverse drug interactions, and/or product toxicity; (4) partner with over 80 national organizations—"Take Time to Care Network, including regulated industry, senior citizen groups, associations, and other government agencies to deliver a message on safety medications, to over 1.5 million people, utilizing more than 1000 interactive events throughout the country each year.

4. Appropriations information related to the issue/issue area (FY00, FY01):
IHS RESPONSE: N/A.

ACF RESPONSE:

- CSE

In FY 2000 $300,000 is being awarded for CSE discretionary demonstration grants. In FY 2001 $4.3 million is requested for direct program operation grants.

- CCB

The tribal child café contract was awarded $1 million dollars in FY 2000 and anticipates awarding the same amount in FY 2001 for this activity.

- ANA

ANA FY 2000 funding is $35 million dollars and $44 million dollars is proposed for FY 2001

AOA RESPONSE: N/A

HCFA RESPONSE: The Sixth SOW is a three-year contract that began for Utah on August 1, 1999 and will end on July 31, 2002. Funding for all activities under Task 2 (of which this is just one of three projects) is projected at approximately $3,000,000.

AHRQ RESPONSE: FY00-$180,000

CDC RESPONSE: As noted in Item #3 above.

HRSA RESPONSE (MCH):

	FY 00	FY01
SPRANS	$109.4 Mil.	same
CISS	$12 mil.	same
Healthy Start	$90 mil.	same

IGA RESPONSE: N/A

SAMHSA RESPONSE: See issue area #'s 4 and 15 of Section I.

FDA RESPONSE: FDA incorporated leveraging in budget narratives for 2001 and beyond.

5. Obstacles to addressing issue/issue area:

IHS RESPONSE: There is a significant lack of understanding and appreciation in both the public and private sectors of AI/AN communities and the many quality of life issues that challenge tribal leadership on behalf of their citizens. In some respects, tribal leadership does not always have the benefit of information they need about opportunities for their communities.

ACF RESPONSE: Oftentimes certain statues or possibly regulations prevent funds being transferred to other federal agencies or sister offices in order to fund a joint project or leverage funding for a project. Remote reservation areas do not have the human resources available needed to meet the related service needs of HS children and families especially children with disabilities.

AOA RESPONSE: Developing and sustaining partnerships involves a commitment of staff time. Efforts to enhance further the priorities of the AoA Central and Regional Offices would need to be made.

HCFA RESPONSE: Tribes are unfamiliar with the way in which the Medicaid program is administered as a Federal/State partnership. Additionally, there are unique problems associated with access to health services. For example, the Indian Health Service provides coverage of illness and/or injury only up to 180 days when residing off of the reservation. After this time, it is up to the individual, or designated family member, to pay for health care either through self-pay or insurance.

AHRQ RESPONSE: AHRQ is a research agency and is limited by statute to activities related to research
CDC RESPONSE: Long history of strained relationships between many state and tribal governments; Misconceptions AI/AN populations within states generally benefit from funds provided by CDC to state health departments;

HRSA RESPONSE (MCH): Limited funding.

IGA RESPONSE: Permanent staff needed to foster and explore ways to create partnerships on tribal issues.

SAMHSA RESPONSE: Some States erroneously believe that IHS funds all American Indian/Alaska Native substance abuse and mental health programs.

FDA RESPONSE: N/A

6. Strategies to overcome obstacles:

IHS RESPONSE: Continued efforts to educate and provide appropriate information to key individuals in both the public and private sector is necessary on the part of both the IHS and tribal leadership and national/regional Indian organizations.

ACF RESPONSE:

- HS

HS programs are required to form Health Services Advisory Committees designed to address program issues related to the health needs of children and families. These committees include IHS personnel, WIC representatives, LEA personnel involved with

IDEA-Part C services, private health practitioners, etc. HS/EHS programs are forming MOAs with states and Tribes to serve as work placement sites for participants of TANF programs.

- ANA

ANA can oftentimes facilitate collaborative efforts due to its historic participation in efforts to increase partnerships across ACF, HHS and to other Departments.

AOA RESPONSE: : Coordinating with other organizations to promote coordination and collaboration.

HCFA RESPONSE: See item #3.

AHRQ RESPONSE: Tribes can submit research grant applications to AHRQ to engage in research on creative approaches/partnerships for improving the efficiency of health care services for tribes under the authority of its "Program Announcement."

CDC RESPONSE: As funds permit and as appropriate, CDC can often function as an intermediary to facilitate improved relationships between state and tribal governments, particularly in regard to collaborative efforts to implement prevention programs, conduct community-based research, and improve tribal public health infrastructure; Better educate CDC project officers and grant/cooperative agreement awardees about the need to ensure benefits to AI/AN populations;

HRSA RESPONSE (MCH) Encourage collaboration/partnerships, particularly in priority areas under Agency Strategic Plan

IGA RESPONSE: IGA has a permanent Senior Advisor for Tribal Affairs. This individual will work collaboratively with other Federal agencies, states, and private businesses to establish partnerships with Indian tribes.

SAMHSA RESPONSE: SAMHSA Centers continue to educate the state directors that IHS funding does not meet the health needs of Indian communities, and that states need to consider tribes and tribal organizations in their funding plans. And SAMHSA will continue to provide technical assistance to tribal communities to successfully compete as state subrecipients.

FDA RESPONSE: FDA is building its leveraging infrastructure by: reflecting leveraging strategies in budget and planning documents; developing a data base system for leveraging; convening leveraging "exchanges" – forums to learn and share about leveraging; developing and maintaining a leveraging intranet site; developing a handbook and processes for leveraging proposals; and establishing an Agency Leveraging Consultant Panel to address novel or sensitive issues. For more details on FDA's leveraging initiatives, see http://www.FDA.gov.html ; http://www.fda.gov/oc/leveraging/default.htm; http://www.fda.gov/oc/leveraging/perfplan.html

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

IHS RESPONSE: Leo J. Nolan, Senior Policy Analyst – External Affairs, Office of the Director, Indian Health Service, 301/443-7261

ACF RESPONSE: Virginia Apodaca, OCSE (202) 401-9376, Tom Tregear,Chief, American Indian Programs Branch/HSB, (202) 205-8437, Robert M. Laue, Tribal Assistance Program Specialist, Division of Tribal Services, OCS/ACF, (202) 401-5040, Ginny Gorman, Child Care Specialist; (202) 401-7260, Sharon McCully, Executive Director, Intra-departmental Council on Native American Affairs/ANA, (202) 690-5780

AOA RESPONSE: M. Yvonne Jackson, Director, OAIANNHP, (202) 619-2713

HCFA RESPONSE: John Hebb, Lead, Disparities Reduction, PRO SOW -- (410)-786-6657 Linda Brown -- (202)-690-6257

AHRQ RESPONSE: Wendy Perry, Senior Program Analyst 301-594-7248

CDC RESPONSE: Ralph T. Bryan, MD, Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, , Office of the Director, CDC 505-248-4226
Dean S. Seneca, MPH, Minority Health AI/AN Program Specialist, Office of the Associate Director for Minority Health,, Office of the Director, CDC, 404-639-7210

HRSA RESPONSE: Karen Garthright, Public Health Analyst, Office of Minority Health, 301-443-9424.

SAMHSA RESPONSE: Steve Sawmelle Intergovernmental Coordinator , Office of Policy and Program Coordination, (301) 443-0419

FDA RESPONSE: Bonnie Malkin, Office of the Commissioner, Office of the Senior Associate Commissioner, (301) 827-3314

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

#2		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Establish HHS Advisory Committee	• Establish a Departmental Advisory body that includes tribal leaders. • Develop website for American Indians to make their need known or respond to issues that affect them. • Assure that all tribes are internet capable • Establish an Indian desk in all HHS agencies to allow better access to resources and technical assistance.	IGA

1. **Public Law(s) or authorization related to this issue/issue area:**
President's Executive Order 13084 of May 14, 1998 "Consultation and Coordination With Indian Tribal Governments

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IGA to explore and provide feedback to the recommendation to establish a Departmental Advisory body that includes tribal leaders. Other possibilities could be: 1) to expand the Inter-Agency Tribal Consultation Workgroup to include tribal membership, or the establishment of a Tribal Consultation Advisory Board. Regarding the recommendation to develop a website for AI/ANs to communicate their needs or to respond to issues that affect them, the IGA will consult with the national Indian organizations to collaborate and partner on ways to provide better communication. A decision could be made to use IHS or other mechanisms such as intermediate national or regional organizations and conferences, or establish specific structures for ongoing advice from Indian communities as outlined in the consultation policy.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
The Office of Intergovernmental Affairs is the designated lead office for tribal consultation within HHS located in the Immediate Office of the Secretary. IGA serves as the Department's liaison to state and local and tribal governments. The IGA, along with ASMB, IHS, ANA and OMH, has convened for the department an annual meeting of Indian people to present their appropriation needs and priorities for FY 2001 and FY 2002. The IGA managed 5 Regional Listening Councils for the Deputy Secretary and Director, Indian Health Service in 1998 and 1999. Currently, IGA is the lead office for planning a National Tribal Consultation Forum on July 19-20 as follow up to the 5 Listening Councils. The Planning Committee includes tribal leaders and National organizations.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
Appropriations/budget is not available for needed staff to carry out the responsibilities of the Department's consultation policy.

5. **Obstacles to addressing issue/issue area:**
Permanent staff to carry out the responsibilities of the Department's consultation policy is needed. Currently, only one position has been established to carry out these functions.

6. **Strategies to overcome obstacles:**

IGA has detailed staff from the IHS to serve as the Senior Advisor on tribal issues and to provide leadership for the HHS on tribal initiatives since 1998. The IGA established and attempted to recruit for this position. Tribal consultation was sought and tribal leaders on the review panel advised against selecting the candidates interviewed. The position of Senior Advisor for Tribal Affairs is currently being announced. This vacancy announcement closes on July 13, 2000. With no additional staff authorized, IGA must explore ways to obtain additional staff support from other OPDIVs through details, consider IPAs with tribes, establish one-year internship to assist the Senior Advisor (funding could be shared by both federal and tribal). Would tribes participate regularly in this initiative and value this activity?

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
Andrew D. Hyman, Director, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, Office of Intergovernmental Affairs, (202) 690-6060

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

#3		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Concern about another consultation process without clear follow up.	Establish a plan and timeline for achieving results to the Listening Council meetings.	IGA

1. Public Law(s) or authorization related to this issue/issue area: NA

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:

The IGA needs to hire a permanent Senior Advisor for Tribal Affairs and two permanent staff to carry out the responsibilities of implementing the Department's Consultation Policy as well as following up to the outcomes and plans as a result of the regional Listening Councils and the National Tribal Consultation Forum that is scheduled for July 19-20, 2000.

3. OPDIV/STAFFDIV activities to date on this issue/issue area:
A permanent Senior Advisor for Tribal Affairs, Office of Intergovernmental Affairs, was hired on December 3, 2000.

4. Appropriations information related to the issue/issue area (FY00, FY01):
Appropriations/budget is not available, funding available only for the Senior Advisor position.

5. Obstacles to addressing issue/issue area:
Appropriations/budget is not available for additional staff as prescribed in the Secretary's Consultation Policy.

6. Strategies to overcome obstacles:
Elevate the priority of tribal consultation.

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
Andrew D. Hyman, Director, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, Office of Intergovernmental Affairs, (202) 690-6060

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

#4		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
States do not have adequate outreach services in rural areas of the states.		IGA

1. **Public Law(s) or authorization related to this issue/issue area:**

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
Elevate awareness of rural and tribal needs in the states.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

5. **Obstacles to addressing issue/issue area:**

6. **Strategies to overcome obstacles:**

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IGA Response: Andrew Hyman, Director, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, (202) 690-6060

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

#5		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Tribes need to have access to more than just demonstration projects (i.e., research and other grants).	• HHS should implement a pilot program for direct funding to tribes from agencies rather than through states. • Look beyond IHS funding to identify other funding sources that should be available to tribes. • Initiate and develop tribally specific grants.	ACF SAMHSA AHRQ NIH ANA IHS AOA OGA CDC HRSA FDA HCFA

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: N/A.

AOA RESPONSE: OAA Title VI (Timeline – long term/ongoing)

HCFA RESPONSE: Through its efforts described under Issues # 14, 17 and 35, HCFA is attempting to address these issues.

AHRQ RESPONSE: N/A

CDC RESPONSE: CDC funds multiple projects that go beyond the scope of "demonstration" and include direct funding to tribes— most of which are highlighted in the response to Issue #5.

HRSA RESPONSE: (MCH) Statutory eligibility provisions governing Federal-State programs under Title V of the Social Security Act and Section 1910 of the Public Health Service Act currently prohibit direct funding to tribes. On the other hand, Title V special projects grants and Healthy Start and other projects funded under authority of Section 301 of the Public Health Service Act have offered MCHB opportunities assist tribes in a variety of ways through a variety of mechanisms.

SAMHSA RESPONSE: NOTE: As described in detail in several of the preceding issue areas (e.g., #'s 4, 8, and 15 of Section I), SAMHSA funds tribes directly as well as through the states.

FDA RESPONSE: Public Health Service Act, Chap. 288—37 Stat. 309 (1912); 42 U.S.C., subsection 201 et. seq., and P.L. 106-107 (Simplification of Federal grant programs for the benefit of recipients.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: The White House Domestic Policy Council started an effort government-wide in 1999 to identify federal programs that could potentially provide direct funding to tribes rather than through states. Although the list is not complete, it does include HHS programs. An analysis of the list should be done to determine definitively which programs can institute a direct funding mechanism to tribes and what types of legislative, regulative and/or administrative changes would need to be made for direct funding to occur and by when.

AOA RESPONSE: AoA provides Title VI funds directly to the Tribes and has proposed setting aside funds for Tribes for the National Family Caregiver Support Program.

HCFA RESPONSE: Through its efforts described under Issues # 14, 17 and 35, HCFA is attempting to address these issues.

AHRQ RESPONSE: See #3 below.

HRSA RESPONSE: (MCH) Continue as in past.

FDA RESPONSE: : FDA is working with the Office of Management and Budget to develop uniform administrative rules and common application and reporting systems; replace paper with electronic processing in administration of grant programs; and to identify statutory impediments to grants simplification.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: Except for raising this issue with the Department at various opportunities by IHS leadership and the development of the DPC list, no other activity has occurred.

AOA RESPONSE: See #2 above.

HCFA RESPONSE: Through its efforts described under Issues # 14, 17 and 35, HCFA is attempting to address these issues.

AHRQ RESPONSE: AHRQ supports research through awarding of grants. Tribes and multi-tribal organizations are eligible to apply for AHRQ grants under "Requests for Applications" and the agency's "Program Announcement."

HRSA RESPONSE (MCH) Healthy Start projects have included grants to tribal coalitions, (e.g., PeeDee). (See Issue Number 35).

FDA RESPONSE; FDA will continue to post opportunities on the FDA home page and provide links to the Department of Health and Human Services' GrantsNet home page, and CODETalk. FDA will also promote opportunities through meetings, conferences, and forums.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: N/A

AOA RESPONSE: Title VI – FY 2000 - $18,457,000, Title VI – FY 2001 – requesting a 5 million dollar increase., AoA has requested proposed set aside funds for the National Family Caregiver Support Program.

HCFA RESPONSE: Through its efforts described under Issues # 14, 17 and 35, HCFA is attempting to address these issues.

AHRQ RESPONSE: N/A

HRSA RESPONSE: (MCH) For FY 00, $90 million, for FY 01, the same.

FDA RESPONSE: N/A

5. Obstacles to addressing issue/issue area:
IHS RESPONSE: Direct funding to tribes may take legislative changes, and in some cases regulatory and administrative changes. It will also require educating key HHS staff about the eligibility of tribal governments to these types of programs and educating staff about the often contentious nature that exists between tribal governments and states. It is unlikely that states would willingly turn over to tribal governments the appropriate shares from HHS state block grants.

AOA RESPONSE: N/A

HCFA RESPONSE: Through its efforts described under Issues # 14, 17 and 35, HCFA is attempting to address these issues.

AHRQ RESPONSE: There is little familiarity with AHRQ in Indian country.

HRSA RESPONSE: (MCH) Not applicable. Applicants must meet geographical, organizational, and infant mortality eligibility requirements.

FDA RESPONSE: N/A

6. Strategies to overcome obstacles:
IHS RESPONSE: See #5 above.

AOA RESPONSE: N/A

HCFA RESPONSE: Through its efforts described under Issues # 14, 17 and 35, HCFA is attempting to address these issues.

AHRQ RESPONSE: A few years ago, AHRQ sent letters to all tribal leaders to familiarize them with the agency. We plan to do this again once AHRQ's tribal consultation plan is vetted with the tribes. AHRQ is also trying to get the word out to Indian country of particularly pertinent funding opportunities ("Requests for Applications") by sending letters to all tribal leaders about such opportunities. AHRQ has and will expand on efforts to get the word out to Indian organizations such as NIHB and the Association of American Indian Physicians and get news of funding opportunities posted on web sites frequented by tribal officials.

HRSA RESPONSE: N/A

FDA RESPONSE: FDA invites ideas to make it easier for State, local, and tribal governments and nonprofit organizations to apply for and report on Federal grants.

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
IHS RESPONSE: Leo J. Nolan, Senior Policy Analyst – External Affairs, Office of the Director, Indian Health Service, 301/443-7261

AOA RESPONSE: Yvonne Jackson, Director, OAIANNHP, (202) 619-2713

HCFA RESPONSE: Through its efforts described under Issues # 14, 17 and 35, HCFA is attempting to address these issues.

AHRQ RESPONSE: Wendy Perry, Senior Program Analyst 301-594-7248

HRSA RESPONSE: Henry Spring, M.D., Director, Division of Perinatal Systems and Women's Health, 301-443-0543.

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

#6		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Need to address the impact of welfare reform on American Indians/Alaska Natives		ACF

1. **Public Law(s) or authorization related to this issue/issue area:**
ACF RESPONSE: Title IV-D of the Social Security Act (Child Support Enforcement -CSE) The Head Start Act, as amended Section 412 of P.L. 104-193 addressing direct funding and administration of Tribal Family Assistance Grants to Indian Tribes does not provide for research and evaluation of the TANF program.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

ACF RESPONSE:

- CSE

OCSE will be providing direct Federal funding to Indian Tribes and Tribal organizations including Alaskan Natives and Villages under Section 455(f) of the Social Security Act for them to operate their own Tribal Child Support Enforcement programs upon publication of the final rule. ACF is working on a pilot sites that are targeted to economic development strategic planning and implementation as an approach in addressing welfare reform by bringing economic development into Indian community.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
ACF RESPONSE:

- CSE

Tribal Consultations were held across Indian country in preparation of the Tribal Direct Funding NPRM

- TANF

ACF approved a five-year research evaluation project, "Welfare-to-Work: Monitoring the Impact of Welfare Reform on Indian Families and Children." The overall purpose of this longitudinal study conducted by Washington University, St. Louis, is to monitor and document the implementation and assess the impact of welfare reform on American Indian families and reservations in Arizona resulting from the State and tribal responses to the TANF program. Extensive demographic, contextual, socio-economic and case level data is to be compiled from a variety of sources including administrative records, tribal documents, interviews, and site visits.

In FY 2000 – 2001, ACF's Office of Policy, Research and Evaluation (OPRE) has a study (OPRE-99-01) in progress to develop national-level research information on tribal TANF that will be responsive to the needs of tribal governments in making decisions on initiating their own TANF programs, as well as the needs of policymakers at Federal, State, and local levels. Division staff is participating with OPRE in this study effort.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

ACF RESPONSE: Not Applicable

5. **Obstacles to addressing issue/issue area:**

ACF RESPONSE: There is an immediate demand for HS/EHS programs to provide full day/full year services. Programs do not automatically receive funds to meet this demand for extended services unless they successfully apply for highly competitive funds on an annual basis. These competitive funds, however are based upon annual appropriations and the level of available funds is not enough to meet the requested amount.

6. **Strategies to overcome obstacles:**
ACF RESPONSE: The President has proposed an increase of $1 billion, the largest ever in a single year for HS. The President's budget also includes an ambitious proposal for child care including an $817 million dollar increase in the Child Care Development Fund (CCDF) block grant to help subsidize care for more families. Tribes would get $16 million for affordable

child care. In addition, the budget includes an early learning fund to provide $3 billion over 5 years to improve quality of child care for the youngest children. Tribal governments would get about $12 million of these dollars in the first year.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
ACF RESPONSE: Virginia Apodaca, OCSE, (202) 401-9376, Tom Tregear, American Indian Programs Branch, HSB; (202) 205-8437 Robert M. Laue; Tribal Assistance Program Specialist, division of Tribal Services, OCS/ACF; (202) 401-5040

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

#7		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
• Budget consultation discussions center around forgone conclusions, loss of opportunity to influence outcome. • HHS should allow for joint funding of projects to fund services more comprehensively.	• Provide tribes the opportunity to impact long-term planning for the budget.	All OPDIVs/STAFFDIVs

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

AOA RESPONSE: President's memorandum of April 29, 1994 titled, "Government to Government Relationship with Native American Tribal Governments and Executive Order 13175.

HCFA RESPONSE: Refer to Issue #1

AHRQ RESPONSE: N/A

CDC RESPONSE: This year CDC implemented its first systematic effort to engage tribal leaders, governments, and organizations in the CDC budget planning process, and the CDC/ATSDR AI/AN Budget Planning and Priorities Meeting will now be an annual *event.* Public Health Service Act, particularly Title III, General Powers and Duties of the Public Health Service; The Indian Health Care Improvement Act; HHS Policy on Consultation with AI/AN Tribes and Indian Organizations

HRSA RESPONSE: See Issue #12 Response.

SAMHSA RESPONSE: N/A

ACF RESPONSE: See Issue # 12 for ACF program authorization. Native American Programs Act of 1974, as amended. (ANA)

FDA RESPONSE: N/A

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE:
- Continue to work with the Area I/T/U budget teams to improve their participation in the annual budget formulation process.
- Continue to encourage the Area budget teams to facilitate full participation by tribes and local health program leadership.

AOA RESPONSE: AoA held a Tribal Listening Session on August 8, 2000. Tribal representatives were able to express their concerns/comments/ideas.

HCFA RESPONSE: Refer to Issue #1

AHRQ RESPONSE: Per AHRQ's draft tribal consultation plan, AHRQ plans to take part in the Department's annual budget meetings with the tribes to identify tribal desires regarding AHRQ (AHRQ participated in the first two annual meetings). As needed, i.e., when AHRQ is considering undertaking activities of particular import/interest to tribes, and if the timing is appropriate, AHRQ may request time at the departmental tribal budget consultation meetings to make presentations to the assembled tribal group to get feedback and input for its budget process. Alternatively, AHRQ may send out information to tribes in advance of a planned budget meeting and request feedback from the tribal representatives at the meeting.

CDC RESPONSE:
- Active/enhanced involvement in ITCWG, including participation in the July 2000 National Listening Council;
- Strengthen/expand partnerships with IHS;

Conduct an annual, CDC-wide AI/AN Budget Planning and Priorities Meeting;

IGA RESPONSE: Need to establish higher awareness of tribes/consultation, etc and initiate consultation very early in the budget process.

SAMHSA RESPONSE: SAMHSA will work with IGA, ASMB and IHS in the implementation of findings and recommendations from the HHS budget consultation meetings with tribal leaders, and will consult with tribal leaders regarding existing and proposed activities and projects.

ACF RESPONSE: See issue #12

FDA RESPONSE: N/A

3. OPDIV/STAFFDIV activities to date on this issue/issue area:

IHS RESPONSE:
- The national IHS budget formulation activities begin in January and all critical local I/T/U input is completed in advance of the date when the Agency submits its initial budget request to the Department.
- Local I/T/U budget teams are kept informed of the budget formulation timetable and critical decisions by the Secretary, OMB and Congress in order to ensure that they are aware of opportunities to influence key decisions on the budget.
- Facilitate tribal and urban leadership meetings with key decision makers in the Department and OMB prior to major decision points.

AOA RESPONSE: AoA held a planning meeting with Regional representatives, Tribal Organizations and Native American Resource Centers on May 11 and 12 to discuss and develop upcoming Tribal Listening Sessions.

HCFA RESPONSE: Refer to Issue #1

AHRQ RESPONSE: AHRQ has taken part in the first two departmental tribal budget consultations.

CDC RESPONSE:
- Participation in ITCWG activities, including this document;
- Numerous partnerships, staff exchange, and intra-agency agreements between IHS and CDC
- Conducted first annual AI/AN Budget Planning and Priorities Meeting in Atlanta, March 200;
- Examples of CDC participation in federal partnerships supporting public health initiatives for tribal communities:
  - CDC, IHS, and BIA jointly supported the development of the *Circle of Life* curriculum;
  - The NDEP is a CDC/NIH joint initiative, intended to increase public awareness about the seriousness of diabetes and to improve the quality of care for people with diabetes;

IGA RESPONSE: The IGA has convened the first and second Budget Consultation meetings with tribal governments to present their appropriation needs and priorities for FY 2001 and 2002. (See #12.) The Assistant Secretary for Management and Budget convened a meeting with tribal leaders and the Budget Review Board on June 9, 2000.

SAMHSA RESPONSE: SAMHSA has participated in the annual budget consultation meetings with tribal leaders, led by IGA, ASMB, and IHS. SAMHSA has a well established track record in working with American Indian and Alaska Native populations, including close collaboration with the Indian Health Service. Working for and with AI/AN communities has always been an integral part of SAMHSA's mission and practices. Most of SAMHSA's AI/AN-related efforts have been with community based organizations and National organizations, such as the National Association for Native American Children of Alcoholics (NANACOA). Although past consultative processes have been ad hoc and related to specific projects, during the development of the SAMHSA Strategic Action Plan, SAMHSA widely and formally reached out to communities throughout the Nation. Three focus groups were held with members of tribal communities to obtain their views; subsequently, their comments and concerns were reflected in the Strategic Plan. SAMHSA has now developed a Tribal Consultation Plan, a major underpinning of which is that there is a special relationship between the government of the United States and tribal governments. Although the Plan is not confined to consultation with Federally-recognized tribes alone, it recognizes and respects the government-to-government level of the consultation. While the Plan puts in place a formal consultation process, it continues to encourage use of the very effective personal and ad hoc communications that have served SAMHSA and tribal communities well in the past. The Plan's goal is to expand SAMHSA's communication circle with tribal leaders and communities.

ACF RESPONSE: ACF attends the annual HHS Tribal Budget Consultation meeting to gain knowledge about tribal budget issues. In ANA, Commissioner meets regularly throughout the year with tribal and community representatives to keep current with concerns and issues relating to funding priorities and joint projects. Across ACF there has been an increase in joint activities and working across program lines.

FDA RESPONSE: N/A

4. Appropriations information related to the issue/issue area (FY00, FY01):
IHS RESPONSE:

AOA RESPONSE: N/A

HCFA RESPONSE: Refer to Issue #1

AHRQ RESPONSE; N/A

CDC RESPONSE: Joint funding of IHS-sponsored Tribal Epidemiology Centers proposed in FY 2002 budget initiative; For FY 2000, via various intra-agency agreements, IHS provided approximately $2.69 million to CDC and CDC provided approximately $2.73 million to IHS;

IGA RESPONSE: N/A

SAMHSA RESPONSE: N/A

ACF RESPONSE: See issue #12

FDA RESPONSE: N/A

5. Obstacles to addressing issue/issue area:
Competing demands on local tribal leadership and the subsequent loss of the ability to exercise influence on timely basis.

AOA RESPONSE: N/A

HCFA RESPONSE:
Refer to Issue #1

AHRQ RESPONSE: The need to consult with all 550+ federally recognized tribes will be a challenge for AHRQ, which is a small agency with no field operations.

CDC RESPONSE: Limited funds to directly engage tribal representatives in consultation; Bureaucratic obstacles to joint funding of projects by more than one Agency (OPDIV);

IGA RESPONSE:
One permanent position to handle tribal issues in the Office of Intergovernmental Affairs is not adequate.

SAMHSA RESPONSE: While the Department's budget consultation process is firmly in place, consultation between SAMHSA and American Indians/Alaska Natives will not be limited to one or a few strictly defined pathways. Consultation will be both flexible and structured. Although SAMHSA has engaged in much dialogue with AI/ANs over many issues, there continues to be the need for more discussions about the best mechanisms for facilitating consultation.

ACF RESPONSE: Congressional approval of the FY 2001 President's budget for ACF.

FDA RESPONSE: N/A

6. Strategies to overcome obstacles:
IHS RESPONSE: Continue to improve the dissemination of information and encourage tribal leadership to participate on a timely basis.

AOA RESPONSE: N/A

HCFA RESPONSE: Refer to Issue #1

AHRQ RESPONSE: First, once the tribal consultation plan is vetted with the tribes, AHRQ will send all federally-recognized tribes information about the agency to familiarize them with us and what we do. AHRQ will welcome feedback. Then, as needed and appropriate, AHRQ will send out letters addressing issues requiring consultation to all 550+ tribes. Use may also be made of the AHRQ web site as well as that of IHS and perhaps others that are regularly consulted by many tribal officials. AHRQ will apprise all federally recognized tribes of decisions on matters for which consultation was sought. As appropriate, AHRQ may also make use of the annual departmental budget consultation meetings to obtain tribal input on budgetary matters.

CDC RESPONSE:
Broaden/invigorate search(es) for traditional and innovative funding sources;
Expand partnerships with non-governmental organizations;
Dedicate more existing CDC professional staff to AI/AN issues;

SAMHSA RESPONSE: SAMHSA will consult with tribal leaders regarding existing and proposed activities and projects. SAMHSA is committed to including tribal leaders in discussions about issues pertaining to these activities, as well as collaboratively developing the most appropriate mechanisms for consultation.

ACF RESPONSE: ACF will continue to host tribal forums as a form of outreach, communication and consultation to Tribes.

FDA RESPONSE: N/A

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
IHS RESPONSE: June Tracy, Legislative Analyst, Legislative and Congressional Affairs, Indian Health Service, 301/443-7261

AOA RESPONSE: Yvonne Jackson, Director, OAIANNHP, (202) 619-2713

HCFA RESPONSE: John Hebb, Lead, Disparities Reduction, PRO SOW –(410) 786-6657 Linda Brown – (202) 690-6257

AHRQ RESPONSE: Wendy Perry, Senior Program Analyst 301-594-7248

CDC RESPONSE: Ralph T. Bryan, MD, Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, , Office of the Director, CDC, 505-248-4226, Dean S. Seneca, MPH, Minority Health AI/AN Program Specialist, Office of the Associate Director for Minority Health,, Office of the Director, CDC, 404-639-7210.

IGA RESPONSE: Andrew D. Hyman, Director, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, (202) 690-6060

SAMHSA RESPONSE: Steve Sawmelle ,Intergovernmental Coordinator , Office of Policy and Program Coordination, (301) 443-0419

ACF RESPONSE: Alexis Clark, Budget Analyst, ACF Office of Legislation and Budget, (202) 401-4530

FDA RESPONSE: N/A

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

#8		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Contract Support Costs – Administration Costs	• Raise ceiling on indirect costs for health service programs • Raise funding level for Head Start	ACF IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: N/A

ACF RESPONSE: N/A

ACF RESPONSE: Part 1301.32 –Limitations on costs of development and administration of a HS/EHS program.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

ACF RESPONSE: A waiver can be requested allowing a HS/EHS program to exceed the HS/EHS program to exceed the 15% threshold on administrative costs for a specific period of time not to exceed 12 months.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

ACF RESPONSE: Head Start regulations provide a waiver provision under certain conditions.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

ACF RESPONSE: Under the Clinton Administration, the HS budget as been increased from $2.1 billion to $4.1 billion dollars. The Indian Head Start Programs have increased to 174 grants which includes 29 Early Head Start programs. HS has been opened to "unserved Tribes" during this Administration as well.

5. **Obstacles to addressing issue/issue area:**

ACF RESPONSE: The waiver provision to exceed the 15% threshold may meet the needs of a limited number of Tribes.

6. **Strategies to overcome obstacles:**

ACF RESPONSE: Ensure that Tribes are aware of the waiver provision.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

ACF RESPONSE: Tom Tregear, American Indian Programs Branch Head Start Bureau, (202) 205-8437

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

#9		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Too many obstacles and red tape that tribes encounter when seeking services or information.	Assist tribes maneuver through the federal system by providing contacts in each agency for technical assistance and information dissemination.	IGA

1. **Public Law(s) or authorization related to this issue/issue area:**

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

Establish a user-friendly website. Provide a list of staff contacts in each OPDIV/STAFFDIV, who can walk tribes through "red tape". IGA has established a permanent position of Senior Advisor for Tribal Affairs.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

Appropriations available only for Senior Advisor.

5. **Obstacles to addressing issue/issue area:**

Funding not available to establish staff in IGA in addition to the Senior Advisor.

6. **Strategies to overcome obstacles:**

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IGA: Andrew Hyman, Director, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, (202) 690-6060

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

#10		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Drug trafficking increases an existing high rate of drug and alcohol problems. Unable to provide services for children of divorced couples where one parent resides in the U.S. and the other resides outside the U.S. Placement of children into foster families, group homes for adoption, and placement of the developmentally disabled into care facilities when divorced couples reside in different countries.	Needs involvement at the Secretary's Level.	ACF OPHS

1. **Public Law(s) or authorization related to this issue/issue area:**

OPHS: The Disadvantaged Minority Health Improvement Act of 1990 and the Health Professions Education Partnerships Act of 1998.

ACF RESPONSE: The following laws are related to the issue but do not address issues of foreign birth, international divorce and custody disputes or placement and care of children across country lines. Title IV-E of the Social Security Act, as amended -- Foster Care and Adoption Assistance -- Funds directly to States for state operation of adoption of children with special needs.

Title IV-B, Subparts I and II of the Social Security Act -- The Child Welfare Services program provides grants to States and Indian Tribes for preventive intervention so that, if possible, children will not have to be removed from their homes. In addition, reunification services are available to encourage the return home, when appropriate, of children who have been removed from their families. Title IV-B, Subpart 2 – Promoting Safe and Stable Families. Family Preservation and Family Support Services grants focus on strengthening families, preventing abuse, and protecting children.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

OPHS: OPHS will continue to promote the development of policies and programs within its operation that are geared at addressing the high rates of drug and alcohol abuse among American Indians. OPHS will also continue to utilize the Healthy People 2010 framework to reduce health disparities affecting American Indians especially those that are linked to substance abuse.

ACF has no jurisdiction in international adoptions; the State Department is tasked with this. ACF has no jurisdiction in divorce and custody issues of parents. ACF's role is to provide funds for foster care and adoption to States who determine the IV-E eligibility of the child. There are no actions planned that relate specifically to the issue of ACF support of Tribes trying to assist families in adoption of other tribal members who reside outside of the US.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

OPHS: OPHS involved the American Indian community in the development of the health goals of the nation--Healthy People 2010. One specific goal of HP2010 is the elimination of health disparities. Again, OPHS used the Healthy People framework to develop health promotion and disease prevention objectives to address the issue of high rates of drug and alcohol usage among American Indians.

ACF RESPONSE: There have been no actions to date related specifically to the issue of ACF support of Tribes trying to assist families in adoption of other tribal members who reside outside of the US because there is no jurisdictional authority to do so.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

OPHS: No ear-marked funds are allocated for this specific issue. Every effort will be made to use existing funding mechanisms and resources to develop programs or initiatives that focus on reducing drug and alcohol use among American Indians.

ACF RESPONSE: Some Federally recognized Tribes are eligible to receive direct funding of Title IV-B, Parts I & II. Funding for Tribes' Title IV-B, Part I is taken from the State allotment and is based on the number of children in the Tribe. Tribes must have an approved plan for the operation of a child welfare services program, etc. in order to obtain funding. For the Promoting Safe and Stable Families Program (IV-B, Part II), the total funding for FY2000 was $2,950,000 and is estimated for FY2001 at $3,050,000 for 63 eligible tribes. These funding amounts have to do with family preservation and support, time-limited family reunification services, adoption promotion and support services for children and families.

5. **Obstacles to addressing issue/issue area:**

OPHS: Outside of the Indian Health Service, there is a lack of appropriated funding targeted specifically for this health issue that affects of American Indians.

ACF RESPONSE: The Children's Bureau plays no direct role in the adoption of children. Title IV-E Adoption Assistance funds are paid directly to the states for adoption of children with special needs. State laws govern adoption and the rules and regulations that apply. The Children's Bureau has no jurisdiction over matters outside of state operations.

6. **Strategies to overcome obstacles:**

OPHS: The OPHS will explore avenues to redirect funding to develop initiatives which focus on reducing substance abuse within the American Indian community. Additionally, efforts will be made to develop a coordinated approach to address this issue with other HHS agencies.

ACF RESPONSE: The IRS administers the adoption tax credit in Public Law 104-188 which appears to apply to children of foreign birth. The Bureau of Indian Affairs oversees the Indian Child Welfare Act, which deals with placement preferences for Indian children, however, ACF does not administer this law.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

OPHS: Guadalupe Pacheco, Special Assistant to the Director, OMH, (301) 443-5084

ACF RESPONSE: Vicki Wright, Policy Specialist, 202-401-0406

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

#11		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
• Agency-level consultation processes place a burden on tribes.	• Have one workable consultation process.	IGA

1. **Public Law(s) or authorization related to this issue/issue area:**

HHS Policy on Consultation with American Indian/Alaska Native Tribes and Indian Organizations.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

Establish a clear statement from tribes as to what they expect/want from a consultation process and determine what HHS is willing and able to give. The answers to these questions will formulate a consultation process.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

The current HHS consultation policy prescribes that each OPDIV/STAFFDIV develop a consultation plan. These consultation plans have been sent to all 558 tribes to provide comments before they are finalized. The National Tribal Consultation Forum will provide a forum for additional comments from AI/ANs.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

5. **Obstacles to addressing issue/issue area:**

6. **Strategies to overcome obstacles:**

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

IGA: Andrew D. Hyman, Director, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, (202) 690-6060

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

# 12		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
HHS Tribal Affairs Advisor	Fill permanent positions in the OS/Intergovernmental Affairs Office.	IGA

1. Public Law(s) or authorization related to this issue/issue area:

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:

A Senior Advisor for Tribal Affairs position was filled. A permanent staff person to carry out the responsibilities of the HHS policy for consultation will alleviate the largest barrier to improving federal/tribal relations for reporting, consultation, and ongoing communications.

3. OPDIV/STAFFDIV activities to date on this issue/issue area:

IGA Response: IGA has permanently filled the Senior Advisor position.

4. Appropriations information related to the issue/issue area (FY00, FY01):

5. Obstacles to addressing issue/issue area:
Appropriations available only for Senior Advisor Tribal Affairs position.

6. Strategies to overcome obstacles:

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
Andrew Hyman, Director, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, (202) 690-6060

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

# 13		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
	Elevate the position of the IHS Director to the Assistant Secretary level.	IGA

1. Public Law(s) or authorization related to this issue/issue area:

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:
The Secretary has supported the elevation of the position of the IHS Director to the Assistant Secretary level and has testified to Congress.

3. OPDIV/STAFFDIV activities to date on this issue/issue area:

4. Appropriations information related to the issue/issue area (FY00, FY01):
N/A

5. **Obstacles to addressing issue/issue area:**

6. **Strategies to overcome obstacles:**

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IGA: Andrew Hyman, Director, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, (202) 690-6060

SECTION V: INTERGOVERNMENTAL RELATIONS AND RELATED ISSUES

Issue # 14		
Issue/Issue Area	Tribal Recommendation	OPDIV/STAFFDIV Assigned
Communication	1.The HHS was encouraged to utilize the national Indian organizations, such as NIHB, NCAI, NCUIH to get the message out to Indian country. But, the Department should also communicate directly with the 558 tribes, as not all tribes belong to these organizations. 2. It was suggested that the IHS Area Directors be delegated the responsibility to ensure communication is delivered directly to each tribe and opportunities for feedback provided.	IHS IGA

1. **Public Law(s) or authorization related to this issue/issue area:**

IHS Response: Response #1: The IHS has established a close working relationship with the National Indian Health Board, the National Congress of American Indians and the National Council of Urban Indian Health. In addition, the IHS works closely with the Tribal Self-Governance Advisory Committee. These organizations are utilized by the IHS to help the Agency disseminate information of importance to tribal and urban leaders. The IHS continues to maintain a relationship with individual tribal governments and uses "Dear Tribal Leader" letters as a means of keeping tribal leadership informed of important activities and events. Additionally, according to IHS policy, a primary responsibility of each Area Director is to consult and inform individual tribal governments.;

IHS Response #2: N/A

IGA Response: N/A

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

IHS Response: IHS Area Directors have a responsibility to consult and inform tribal governments to ensure direction communication is provided and feedback is received.

IGA Response: IGA is responsible for coordinating HHS interaction with the tribes and organizations that represent many of them. IGA recognizes that it is not sufficient to reach out only to national tribal organizations such as NCAI, NIHB, and the Tribal Self Governance Advisory Committee. We also recognize that there are times when the Department must reach out to all federally recognized tribes. Nevertheless, it would be impractical to contact all tribes in every instance of a HHS rulemaking or request for views. Consequently, we are working with NCAI, NIHB, and the Self Governance Tribal Advisory Council to identify a tribal representative in each of the designated Indian Health Service areas with whom the Department can communicate on a regular basis on day-to-day issues involving the Department. Of course, on significant issues, HHS would communicate directly with all federally recognized tribes and tribal organizations.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

IHS Response: Responsibility to ensure communication is delivered directly to each tribe and opportunities for feedback provided has been an integral part of the IHS Area Director's performance evaluation plans since 1997. Element four of the IHS Area Director's Senior Executive Service Work Plan is to provide leadership in support to tribal governments and tribal organizations, and urban Indian programs in capacity development and management of health delivery programs. The IHS Area Directors ensure that tribal consultation is an integral part of HHS/IHS policy development and budget formulation. The Area Directors maintain a system for timely dissemination of important information to tribal leaders. The Areas provide support for full implementation of P.L. 93-638, Indian Self-Determination and Title V of P.L. 94-437, the Indian Health Care Improvement Act, and assure that technical assistance regarding these laws or IHS processes related to these laws is provided as requested by tribes, tribal organizations, and urban Indian programs. The Area Directors ensure that Area operations, and to the extent authorized by Law, Tribal contractors/compactors and urban Indian program officials are in compliance with appropriate policies and procedures. Services provided under contract are monitored in a manner consistent with Title I or Title V contract requirements.

IGA Response: IGA is working with NCAI, NIHB, and the Tribal Self Governance Advisory Committee to establish an appropriate communication system with tribal leaders.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

IHS Response: N/A

IGA Response: N/A

5. **Obstacles to addressing issue/issue area:**

IHS Response: Ensure that Departmental information is received timely enough to share with Indian tribes and tribal organizations during the Area quarterly consultation meetings.

IGA Response: Potential tribal concern over lack of communication/consultation on important issues.

6. **Strategies to overcome obstacles:**

IHS Response: Continue to maintain a close working relationship with the Department's Senior Advisor, Tribal Affairs.

IGA Response: HHS will work hard to assure tribal leaders that they will receive communications and invitations to consult on all major health and human services issues. In addition, HHS will make clear that all tribal leaders are welcome to contact HHS, through the IGA Senior Tribal Affairs Advisor, on any matter.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS Response: Don Davis, Director of Field Operations, Office of the Director, Indian Health Service, (301) 443-1083, and Phyllis Wolfe, Senior Advisor to the Director of Field Operations, Office of the Director, Indian Health Service, (301) 443-1083

IGA Response: Andy Hyman, Director, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, (202) 690-6060

SECTION V: INTERGOVERNMENTAL RELATIONS & RELATED ISSUES

Issue # 15		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Tribes and territories are not permitted to keep TANF block grants until they are used nor are they allowed to transfer a percentage of TANF funds to Title XX, although states are able to do this.		ACF

1. **Public Law(s) or authorization related to this issue/issue area:**

Section 412 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). Public Law 104-193, establishing the Tribal TANF program, require funds to be awarded to eligible Indian Tribes for a three-year funding period.

The inability of Tribal TANF grantees to carry-over unexpended funds from one budget period to the next is no longer valid as stated in the answer to question 3. Indian Tribes however, are not eligible for direct funding under Title XX and therefore can not transfer any TANF funds to Title XX.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:** Not applicable.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

Indian Tribes administering TANF programs may obligate Tribal Temporary Family Assistance Grant (TFAG) funds at any time during the three-year funding period. Only funds not obligated or liquidated within the timeframes set forth in policy and regulations must be returned to the Federal government. This policy was transmitted September 3, 1999 to Indian Tribes administering an approved TANF plan in a Policy Announcement, Transmittal No. TANF-ACF-PA-99-1, as well as in regulations of the Federal Register / Vol. 65, No. 34, published February 18, 2000.

As published in the Federal Register of the Department's final rule indicated above, Tribal TFAG funds may be used that are reasonably calculated to accomplish the purposes of the TANF program. They may not be used to contribute, subsidize, or to be used for non-TANF programs.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

TFAG is calculated under Section 412 (a)(1)(A) of the Social Security Act. The Secretary is required to award to each Tribe that has an approved family assistance plan a tribal TFAG for the fiscal year. The TFAG is based on FY 1994 expenditure date for all Indian families residing in the service area identified by the Indian Tribe, pursuant to Section 412 (b)(1)(C) of the Act.

5. **Obstacles to addressing issue/issue area:**

Currently Tribes are not eligible to apply directly for Title XX funds.

6. **Strategies to overcome obstacles:** Not applicable.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
Robert M. Laue Tribal Assistance Program Specialist, Division of Tribal Services, OCS/ACF, (202) 401-5040

SECTION V: INTERGOVERNMENTAL RELATIONS AND RELATED ISSUES

Issue #16		
Issue/Issue Area	Tribal Recommendation	OPDIV/STAFFDIV Assigned
International Borders:	Tribes along the Mexico/US boarder are subsidizing the cost of emergency medical care for illegal aliens injured or sick that brought to their facility by the INS.	IHS ACF

1. **Public Law(s) or authorization related to this issue/issue area:**

IHS Response: Emergency Medical Treatment and Labor Act, 42 CFR, Sec. 1395dd., which requires medical screening examination, stabilization, and transfer for all patients requesting emergency care. Restricting Welfare and Public Benefits for Aliens, 8 USC, Sec. 1611, which states that an unqualified alien is not eligible for any Federal public benefit. Privacy Act, 5 USC, Sec. 552 (a), which for medical records purposes, does not cover the Undocumented Aliens.

ACF RESPONSE: Not Applicable. The Head Start program assures that enrolled Head Start children receive necessary health screening and treatment, through referral to Medicaid services for which they are eligible by virtue of their families' income status. When necessary, the Head Start program covers the costs of providing direct services as the source of last resort.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

IHS Response:

a. Continue to submit billing/cost documentation to INS for health services related to the Undocumented Aliens.
b. Continue to work with the Tribes and INS in reviewing and formulating policies at the local level.
c. Elevate the problems and discussion with Indian Health Service, Health and Human Services, Immigration and Naturalization Service, and the Border Patrol at the National level.

ACF Response: N/A

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

IHS Response:

a. The Tucson Area Indian Health Service (TAIHS) has met with the Border Patrol and INS to discuss reimbursements and to review the related problems.
b. The TAIHS has sought to develop a working relationship with the Border Patrol and to review policies on custody and humanitarian rescues.
c. The TAIHS has worked with the Tohono O'odham Nation in assisting the Indian Health Service in pursuing reimbursements and related issues of the Undocumented Aliens for services, such as public safety, contagious disease control, etc.
d. The TAIHS has billed INS for services until the determination was made that the Undocumented Aliens were considered humanitarian rescue and not reimbursable.

ACF Response: N/A

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

IHS Response: Not applicable for FY 00 or FY 01.

ACF Response: N/A

5. **Obstacles to addressing issue/issue area:**

IHS Response:

a. No appropriation for servicing this population.
b. The Border Patrol considers transportation of Undocumented Aliens to IHS facilities "humanitarian rescue", which make the provided health services non-reimbursable under INS policy.

c. The influx of undocumented aliens is increasing along the 90-mile reservation boundary with Mexico.

ACF Response: N/A

6. Strategies to overcome obstacles:
IHS Response:

a. Review or develop policies with INS to deal with the Undocumented Aliens that are provided services by IHS or Tribal facilities.
b. At an elevated level, work with Mexican officials and the State Department in dealing with the influx of Undocumented Aliens crossing the reservation border.
c. Establish regional referral centers for the care of the Undocumented Alien population.

ACF Response: N/A

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):

IHS Response: Taylor Satala, Area Director, Tucson Area Indian Health Service, (520) 295-2405, and George Bearpaw, Executive Officer, Tucson Area Indian Health Service, (520) 295-2402

ACF Response: N/A

SECTION V. INTERGOVERNMENTAL RELATIONS

Issue # 17		
Issue/Issue Area	Tribal Recommendation	OPDIV/STAFFDIV Assigned
Consultation	What is the status of current draft plans by OPDIVs? What is the OPDIV accountability to follow the plans? There should be consistency within each OPDIV plan to the Executive Order and Secretary Shalala's policy statement. It was pointed out that consultation is a "two-way street" and that only 3 of the 558 tribes responded so far to the draft consultation plans. Pre-meeting Notice and Document Review – There needs to be adequate notice of meetings with time to review necessary documents in advance.	All OPDIV's

1. Public Law(s) or authorization related to this issue/issue area:
ACF RESPONSE: See ACF Indian Funds chart under Issue #5

AHRQ Response: N/A

AOA Response: Presidential Executive Memorandum dated April 29, 1994 affirming a government- to-government relationship with the Tribes; Executive Order 13175, OAA – Titles II and VI.

CDC Response: Presidential Memorandum titled Government –to – Government relations with American Indian Tribal Governments, 1994 and Executive Order 13175.

IHS Response: The Indian Health Service has had a tribal consultation and participation policy in place since 1997. In fiscal year 2001, the IHS will work with stakeholders (i.e. tribal and urban leadership) to assess consultation in the IHS and revise its consultation processes as appropriate.

FDA Response: N/A

HCFA Response: On May 14, 1998, the President issued Executive Order # 13084 directing Federal agencies to establish regular and meaningful consultations and collaboration with Indian Tribal Governments. The Department's consultation policy, issued August 7, 1997, directs each HHS agency to develop an individualized consultation policy to consult with Tribes to the greatest extent practicable and to the extent permitted by law before taking actions that affect Indian people.

IGA Response: N/A

NIH Response: S. 1880 and HR 3250, legislation that establish the National Center on Minority Health and Health Disparities (the Center) at the National Institutes of Health. The Senate unanimously passed S. 1880 during the current legislative session; H.R. 3250 is still pending before the House.

SAMHSA Response: N/A

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

ACF RESPONSE: ACF has reviewed all tribal comments to date on the ACF tribal consultation plan and has it posted on our web site as a living document, flexible to change based on comments from Indian Country. ACF will continue to encourage Tribes to review and provide further feedback on the ACF Policy and Plan for Native American Consultation through both our web site and regular ACF program component meetings (at central office and regional offices) with Tribes. ACF holds its managers accountable to following and implementing this document. Strengthening the government-to-government relationship between Tribes and the federal government, and self-sufficiency and improved services in Indian Country are the outcomes. The ACF Tribal Initiative will continue to outreach to Tribes and deal with issues across program boundaries in an effort to increase access and improve services. ACF will be receiving tribal input from the four tribal consultation meetings, surrounding our newest program of direct funding to Tribes, being conducted October through November 2000 focused around the Comprehensive Tribal Child Support Enforcement Program Interim Final Rule and Notice of Proposed Rulemaking. Welfare reform is a continuous dialog with Indian Country as ACF continues to meet its responsibilities in serving Tribes and assisting them to move to self-sufficiency.

AHRQ Response: AHRQ will soon send a copy of the consultation plan to all tribes along with information about the Agency. While not explicitly for the purpose of commenting on the consultation plan again, if additional comments are offered at that time, we will try to incorporate them into the consultation policy.

AOA Response: The AoA has a draft consultation plan in the process of being finalized.

CDC Response: Implementation of CDC's Tribal Consultation Policy: Proposed Plan for Tribal Input
Notification: Publicize widely among AI/AN constituents that the CDC is developing it's Tribal Consultation Policy and is seeking AI/AN input regarding the implementation of that policy. Publications to target include, but are not limited to: Indian Country Today; Indian News; NCAI (National Congress of American Indians), NIHB (National Indian Health Board), AISES (American Indian Science and Engineering Society), and AIHEC (American Indian Higher Education Consortium) newsletters; Tribal College Journal; tribal health department newsletters; AI/AN websites, etc. Develop presentations/workshops wherein CDC senior staff have the opportunity to present Agency intentions and solicit input from elected tribal leaders regarding the content, steps, and program needs for CDC's Tribal Consultation Policy. These presentations/workshops would be held in conjunction with established national and regional AI/AN meetings as outlined below:
National Meetings: National Congress of American Indians, National Indian Health Board, Association of American Indian Physicians, Indian Health Service Annual Research Conference, Indian Health Leadership Council of the IHS
Regional Health Board Meetings: Aberdeen Area, Alaska Area, Albuquerque Area, Billings Area, Bemidji Area, California Area, Nashville Area, Navajo Area, Oklahoma Area, Phoenix Area, Portland Area, Tucson Area. (The CDC will invite all Tribal leaders and representatives within the each respective region regardless if they are affiliated with the Area Health Board or National Organization.)

Upon completion of the national/regional meetings, a draft tribal consultation implementation document will be prepared and submitted to NIHB, NCAI, and tribal governments for review and final comment. Thereafter, the finalized document will be presented to NCAI for final approval by resolution. Once this resolution is enacted, the final document will be published in the Federal Register, posted on appropriate federal and AI/AN websites, and made widely available to AI/AN governments and organizations.

Budget Planning: In February 2001, CDC will convene its 2nd Annual AI/AN Budget Planning and Priorities Meeting.

FDA Response: FDA received comments from two (2) tribes. While there were no objections to the content of the draft consultation plan, the Tribes wanted the content to reflect a government-to-government consultation process. FDA's consultation plan has been revised. FDA's consultation process is operational in its Federal State Relations Program. Government-to-government interactions are framed in Agency functional statements. FDA works directly with tribes on activities, i.e. regulations that may have the potential to affect Tribes. For example, FDA uses consultations in collaborative seafood inspection and safety (Hazardous Analysis Critical Control Point (HACCP)) with the Great Lakes Tribes in the Central Region of the United States.

HCFA Response: HCFA will continue to seek further enhancements to its consultation policy statement to make it more responsive and effective for addressing Tribal concerns and issues. The agency will also work to determine how best to conduct Tribal consultations during deliberations of the Indian Health Service (IHS)/HCFA Steering Committee (discussed below at item 3).

NIH Response: S. 1880 and HR 3250, the latter of which is pending before the House, direct the development of a trans-NIH strategic plan for reducing and eliminating health disparities. Because of its commitment and the support of the Secretary, DHHS, for the Center, the NIH has proceeded with the development of the strategic plan, as directed by the pending legislation. The draft strategic plan has been posted on the Internet for public review and comment. This represents one of the mechanisms for Tribal consultation through the review and comment phase of strategic plan development. The draft strategic plan will be revised to reflect the needs and concerns of all of the stakeholders of the Center. In addition to posting the draft strategic plan on the Internet, there is a Native American presence on the Advisory Committee on Research on Minority Health; and tribal input can be transmitted via this group.

Accountability is ensured through the annual requirement for evaluating performance, according to a performance plan whose development is based on the strategic plan. The Department will receive copies of the annual performance reports, which can be disseminated to the tribes for their review.

SAMHSA Response: SAMHSA is planning implementation of its Tribal Consultation Plan. The plan will be finalized when HHS sends to the tribes all the plans of the Operating and Staff Divisions of the Department. For all tribal consultation meetings scheduled, SAMHSA will ensure adequate notice to tribes and tribal organizations of such meetings and will allow adequate time in advance of the meetings for tribes to review any necessary documents.

3. OPDIV/STAFFDIV activities to date on this issue/issue area:

ACF RESPONSE: The DHHS "Policy on Consultation with American Indian and Alaska Native Tribes and Indian Organizations" was issued on August 7, 1997. This policy provides for budget consultation through "an annual meeting of Indian people to present their appropriation needs and priorities." ANA, an ACF program component is designated as one of the four DHHS agencies to organize the annual budget consultation meeting. To date there have been two DHHS tribal budget consultation meetings. The ACF Policy and Plan for Native American Consultation was modeled after the department's plan.

The following selected activities highlight a couple of key issues:

TANF

Extensive tribal consultation activities regarding TANF are detailed in Issue # 35. The development of final regulations for the Temporary Assistance to Needy Families (TANF) program involved ample consultation with Tribes. These regulations provide Tribes the choice to continue to serve their families through states or to receive direct funding.

CSE

About one and a half years ago tribal consultations across Indian Country were completed to discuss the new Tribal Child Support Enforcement Program direct funding to Tribes, prior to publication of regulations. Tribal leaders were notified by a September 29, 2000 letter and the September 13, 2000 Federal Register announcement about upcoming tribal consultations in October – November 2000 to discuss the publication of the Comprehensive Tribal Child Support Enforcement Program Interim Final Rule and Notice of Proposed Rulemaking (NPRM).

(In addition see Issue # 35 question 3)

AHRQ Response: AHRQ prepared a draft tribal consultation plan that was sent by the Department, with the plans of the other components of DHHS, to the tribes. AHRQ received comments from one tribe and will incorporate what it can of that feedback, within the parameters of Departmental policy.

AOA Response: The AoA hosted a Tribal Listening Session on August 8, 2000 in Washington, D.C. with Tribal leaders throughout the country. The Session focused on issues affecting the lives of Indian elders. Recommendations were presented to the Assistant Secretary for Aging. The Administration is currently n the process of reviewing the recommendations and looking at ways to address them.

CDC Response: CDC has formulated a Tribal Consultation Policy Work Group that has outlined a process to develop the Consultation Policy with maximum tribal participation. The comments that CDC has received to date from tribal governments and organizations regarding his approach have been very positive in nature.

The CDC Draft Consultation Policy Statement is the guiding principle for CDC in this consultation process:

> *"The Centers for Disease Control and Prevention (CDC) will honor the sovereignty of American Indian/Alaska Native (AI/AN) Governments, respect the inherent rights of self governance and commit to work on a government-to-government basis. The CDC will confer with Tribal Governments, Alaska Native Corporations and AI/AN communities, before taking actions and/or making decisions that affect them. Consultation will all tribes and AI/AN organizations."*

In addition, CDC conducted its first annual AI/AN Budget Planning and Priorities Meeting in Atlanta, March 2000;

FDA Response: N/A

HCFA Response: Consistent with the guidance provided in both Executive Order 13084 and the Department's consultation policy statement, HCFA developed its draft agency consultation policy statement in 1998. Throughout 1999, each HCFA Regional Office held Tribal consultations on the consultation policy and received comments to improve the statement. These comments, along with those received in response to the Department's request for comments on the policy, were incorporated into the package and a revised policy statement was provided to the Tribes during the Deputy Secretary's Tribal Consultation Forum on July 19, 2000. Generally, the proposed revisions were targeted toward removing obsolete items that had been addressed during the Agency's consultations meetings. One comment that remains to be addressed involves a recommendation to incorporate the Trust Responsibility into the definition of consultation or HCFA's policy statement.

To continue Tribal consultations at the regional and IHS area levels, HCFA has instituted a Native American Contact (NACs) in each of its Regional Offices. The NACs are now beginning to work closely with the Indian Health Service (IHS) Area Offices and are designed to facilitate consultations as well as help ensure that Tribal issues are brought to the HCFA's attention. Because most consultations occur at the Regional level, the NACs are also responsible for ensuring that timely notice of consultations are provided to Tribal members and that they receive information well in advance of the meetings.

Additionally, at the national level, IHS and HCFA have established a Joint IHS/HCFA Steering Committee as a collaborative effort to identify and address AI/AN issues common to both agencies. The Steering Committee meets approximately every three to four months to discuss, strategize and offer resolutions to AI/AN issues brought forward to IHS or HCFA either through their respective internal working structures or by the leadership of Tribal Governments, Tribal organizations, and/or Urban programs. The Steering Committee plans to use Tribal consultations in its deliberations. These consultations will complement and further the intent to the Department's, IHS' and HCFA's consultations. At this time, we are working to determine how best to involve Tribes in these consultations.

NIH Response: Opportunities for consultation with the Native American Tribes and other stakeholders have been provided through a broad consultative process involving regional and national meetings. The most recent opportunity for consultation was provided during the ORMH sponsored April 2000 conference, the purpose of which was to consult with the multi-cultural, multi-racial and ethnic minority community to seek community input for the development of a trans-NIH strategic plan for addressing health disparities and the training needs for diversifying the scientific workforce. Tribal elders and other representatives were especially invited to participate in the millennial conference. Approximately 1000 individuals from across

the nation, including its territories, attended the conference. The recommendations from the conference will be reflected in the final version of the strategic plan.

The Associate Director for Research on Minority Health has a philosophy of grass-roots community involvement in setting priorities. This broad-based consultative process was initiated with the establishment of the Office of Research on Minority Health in 1990. The process began with three regional conferences, during which a 53-member fact finding team listened to the input and concerns from almost 1000 participants from minority and majority institutions, professional organizations, community-based organizations, and Federal agencies. Input was summarized in the form of 13 recommendations, which were further distilled into six priority areas of emphasis. An additional conference was held in 1994, followed by four consensus conferences with the different minority populations and subgroups to gain a deeper understanding of their individual concerns. The conference for Pacific Islanders and Asian Americans was held in Honolulu, Hawaii (January 1996); the Native American Health Research Conference was held in Spokane, Washington (August 1996); the Hispanic American Health Research Conference was held in San Juan, Puerto Rico (November 1996); and the African American Health Research Conference was held in Miami, Florida (November 1996).

SAMHSA Response: SAMHSA has developed a draft Tribal Consultation Plan, which, along with the plans of the other Operating and Staff Divisions, has gone out twice to tribes for review and comment. SAMHSA received one set of comments with specific suggestions for modification of its plan; namely, for consistency in how it refers to tribes (American Indians/Alaska Natives instead of Native Americans) and the need for clarity about the inclusion of tribal governments in consultations. The plan has been revised accordingly. Further, SAMHSA has ensured that there is consistency in its plan with the President's Executive Order on Tribal Consultation and with the Secretary's policy statement on such consultation. Finally, SAMHSA participates in the annual budget consultations with tribal leaders led by HHS' Director of Intergovernmental Affairs (IGA), the Assistant Secretary for Management and Budget, and the Director of the Indian Health Service.

4. Appropriations information related to the issue/issue area (FY00, FY01):
ACF RESPONSE: The President's FY 2001 ACF budget contained over a 14 million-dollar increase for ACF tribal programs and Congress has not yet passed the appropriation at the time this response was prepared. In FY 2000 Tribes received $332,116,000 which is 1% of the total ACF programmatic budget.

AHRQ Response: N/A

AOA Response: No specific appropriation is designated for consultation.

CDC Response: N/A

FDA Response: N/A

NIH Response: No appropriations information is related to the issue of consultation with the Tribes. There is, however, a Presidential executive order, E.O. 13084.

SAMHSA Response: N/A

5. Obstacles to addressing issue/issue area:
ACF RESPONSE: Not Applicable

AHRQ Response: N/A

AOA Response: There is limited funding available to provide all needed services for Indian elders.

CDC Response: Inadequate funding is an ongoing obstacle.

FDA Response: N/A

HCFA Response: Some Tribes have noted that the consultation policy statement does not cover a number of Tribes, since State recognized Tribes are not covered by the Department's or HCFA's consultation policy statement or the Executive Order.

NIH Response: Perhaps the greatest obstacle to a broad-based review and comment on the strategic plan by Native Americans could be dependency on a web based process to which there might be limited access. Limited access could result from insufficient access to computer technology.

SAMHSA Response: There are 558 federally recognized tribes. This large number of tribal entities makes it difficult to pursue meaningful and timely consultation.

6. Strategies to overcome obstacles:
ACF RESPONSE: Not Applicable

AHRQ Response: N/A

AOA Response: AoA will encourage the Title VI programs to increase coordination with other Federal agencies to assist in meeting their needs. The AoA will continue to work with other agencies via the Interagency Task Force for Older Indians.

CDC Response: FY 2002 Budget Initiative noted above.

FDA Response: N/A

HCFA Response: As part of its ongoing consultations with Tribes, HCFA will seek Tribal input on how and the extent in which to include state-recognized Tribal members in its consultations. We will also seek guidance from the Tribes to determine the best approach for conducting consultations at the HCFA Central Office level.

NIH Response: One of the ways of improving access for review and comment is to link the trans-NIH draft strategic plan with the Indian Health Network web page. This is an ORMH-supported initiative, through the Office of Minority Health, DHHS. This web page is maintained and operated by a Native American organization, the Association of American Indian Physicians (AAIP) and its purpose is to disseminate information to the urban and rural reservation communities to tribal governments, health organizations, student health organizations, and to government agencies. Not only is this a potential resource for the NIH for disseminating information about research opportunities and for the recruitment of clinical trial participants, but it can also be used to widely distribute the strategic plan for review and comment by Native Americans.

The opportunity for input into the strategic plan is also provided during the national conference in April 2000 to which tribal elders were invited. In addition, the ORMH Advisory Committee that also has a Native American presence has had an opportunity for review and comment on the plan. Their input will be reflected in the final version of the strategic plan.

There is also a plan to convene an annual Public Interest Organization (PIO) meeting to encourage and promote public input and involvement in the activities of the proposed Center. Representatives of public interest groups, including the Tribes, members of the Advisory Council, and senior Center staff would be invited to participate.

SAMHSA Response: SAMHSA and other Operating Divisions will utilize such national AI/AN organizations as the National Congress of American Indians (NCAI) and the National Indian Health Board (NIHB) to coordinate meaningful tribal consultation. Further, IGA is working with NCAI to develop a plan for more systematic consultation. A list of the most appropriate tribal leaders for regular contact is being developed by NCAI.

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number)

ACF Response: Sharon McCully, Executive Director Intra-departmental Council on Native American Affairs (202) 690-5780

IHS Response: Douglas Black, Director, Office of Tribal Programs, Office of the Director, Indian Health Service, (301) 443-1104

AHRQ Response: Wendy Perry, Senior Program Analyst, 301-594-7248

AOA Response: Yvonne Jackson, Director, OAIANNHP, 202-619-2713

CDC Response: Ralph T. Bryan, M.D., Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention, c/o IHS Epi Program, 5300 Homestead Rd. NE, Albuquerque, NM 87110,
Tel: 505-248-4226, FAX: 505 248-4393, e-mail: rrb2@cdc.gov; and Staff Liaison: Dean Seneca, Minority Health Specialist, Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention, MS-D39, 1600 Clifton Rd. NE, Atlanta, GA 30333, Tel: 404-639-7220, FAX: 404-639-7039, email: zkg8@cdc.gov

FDA Response: N/A

HCFA Response: Linda Brown, (HCFA) Technical Director, (202)-690-6257

NIH Response: John Ruffin, Ph.D, Director, Associate Director for Research on Minority Health and Director, Office of Research on Minority Health. Phone: (301) 402-1366.

SAMHSA Response: Steve Sawmelle, Intergovernmental Coordinator, Office of Policy and, Program Coordination, (301) 443-0419

SECTION V: INTERGOVERNMENTAL RELATIONS AND RELATED ISSUES

Issue # 18		
Issue/Issue Area	Tribal Recommendation	OPDIV/STAFFDIV Assigned
States Reluctant to Consult with Tribes	States continue to be reluctant or even refuse to engage in meaningful discussion and consultation with tribes on many issues that affect Indians. There could be civil right violations in the way some states have systematically excluded tribal participation in resources. For example, the refusal by the State of South Dakota to certify nursing homes on Indian reservations with certificates of need and thus prevent access to Medicaid reimbursements. The State of Idaho refuses to pay the encounter rate to tribes. There was a request for review by the Office of Civil Rights with regard to South Dakota.	HCFA IGA OCR

1. **Public Law(s) or authorization related to this issue/issue area:**

HCFA Response: N/A

IGA Response: N/A

OCR Response: In 1988, the South Dakota Legislature passed a moratorium that prevents Medicaid state dollars from being used to pay for new nursing home beds. The moratorium has been renewed several times, lastly in 1999. This action extended the moratorium for five years.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**

HCFA Response: We are continuing to consult with the National Association of State Medicaid Directors and Tribal leaders on our proposed consultation policy. We will issue the policy as soon as possible thereafter.

IGA Response: IGA recognizes the traditional reluctance of many states to work with tribes in the administration of HHS-funded programs. IGA will meet with the National Governors' Association (NGA) and other state government organizations to discuss this issue in a frank and open manner and identify specific steps to enhance the relationship between states and tribes in the administration of our programs. In addition, IGA will work with the HHS Office of Management and Budget to develop a strategy to educate state program agencies about the unique government-to-government relationship between the federal government and tribes and the implications of this relationship on the administration of HHS-funded programs.

OCR Response: The issue statement indicates that there is a certificate of need (CON), but this is not the case. The CON process was eliminated when the moratorium was passed in 1988. The tribes contend that there are individuals on the nine reservations in South Dakota who are in need of nursing home care, but since there are no nursing homes located on these reservations, they do not have access. The Rosebud Sioux Tribe located in Mission, South Dakota, recently purchased a nursing home near the perimeter of the reservation to provide greater access for Native Americans in need of nursing home care. There are about 200 Native Americans in nursing homes throughout the state of South Dakota, but family members or friends from the reservation who want to visit them often must travel long distances. There are 1745 Native Americans in South Dakota that are Medicare beneficiaries.

The University of North Dakota (UND) has a grant from the Administration on Aging to conduct a national study on Native American issues affecting elders and for advocacy activities to address their concerns. In conjunction with the South Dakota Governor's Workgroup formed to address this issue, UND representatives are in the process of gathering data to show how many Native Americans are in need of nursing home care and would access care if available on the reservation. The HHS Office for Civil Rights will work with Federal and state agencies to assess any civil rights compliance aspects of this issue.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**

HCFA Response: HCFA has prepared a DRAFT letter to the State Medicaid Directors and to the Tribal Leaders informing them that once the letters are issued, the States will have to consult with all Federally-recognized Tribes in their State on Section 1115 Medicaid managed care demonstration waivers, Section 1915(b) freedom of choice waivers, and Section 1915(c) home and community based services waivers prior to submission of the proposal to HCFA. The State would also have to provide a description of the results of the consultation with the proposal or it may not be considered complete, however Tribes would not be allowed to veto a proposal. Again please note, this is only a proposed policy.

IGA Response: IGA has had a preliminary discussion with NGA staff on this matter.

OCR Response: HCFA staff members have participated on the Governor's workgroup for the last two years to resolve the problem of access to nursing homes. The workgroup is composed of state Medicaid staff, tribal officials, and the Department of Interior/Bureau of Indian Affairs and the HHS/Indian Health Service staff. HCFA has also attended periodic meetings of the State Legislature's Subcommittee on State/Tribal Relations. There were two meetings during the interim legislative session with the latest meeting held in late August 2000. One of the state legislators on the committee is a Native American who has been trying to resolve this matter (access to nursing home care) for some time.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**

HCFA Response: N/A

IGA Response: N/A

OCR Response: One option that has been suggested to resolve the problem is for HCFA to pass through 100% of the federal match Medicaid reimbursement to nursing homes directly to IHS. There is no mechanism in place to do this; however, the Indian Health Care Improvement Act could possibly address it. Currently, IHS does not provide long-term care services; it is in need of more than one billion dollars to meet acute health care needs. Therefore, IHS is financially unable to take over this responsibility.

5. **Obstacles to addressing issue/issue area:**

HCFA Response: State Medicaid Directors have indicated serious concerns regarding the proposed policy and its implementation.

IGA Response: State reluctance to work with tribes and lack of knowledge among state program agencies about the rights of tribes in the administration of federally-funded programs.

OCR Response: There are several obstacles including:
1) There is no means for HCFA to pass through 100% federal match of Medicaid reimbursement directly to IHS or the tribes.
2) The state legislature has continued the moratorium since 1988. During the 1999 legislative session, the moratorium passed for another five years.
3) HCFA, IHS, and OMB would need to coordinate their efforts to change regulations and establish policy.

6. **Strategies to overcome obstacles:**

HCFA Response: We will continue to consult with the State Medicaid Directors and the Tribal Leaders to resolve the issues raised, if possible, prior to release of any consultation policy.

IGA Response: See response to item number 2 above.

OCR Response: Establish a task force of HCFA, IHS, OCR and OMB to resolve the problems.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**

HCFA Response: Nancy Goetschius, (HCFA) Health Insurance Specialist, (410) 786-0707

IGA Response: Andrew Hyman, Director, Eugenia Tyner-Dawson, Senior Advisor for Tribal Affairs, (202) 690-6060

OCR Response: Cindy Myers, State Program Coordinator, 303-844-7116
Kathleen O'Brien, OCR, 202-219-2829

SECTION V: INTERGOVERNMENTAL RELATIONS AND RELATED ISSUES

#19		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Indian Health Care Improvement Act: What is the Administration's position on the consensus bill drafted by tribal/IHS/Urban consultation? Will the Administration be supporting this bill at the upcoming hearings?		ASL

Each OPDIV/STAFFDIV assigned the issue/issue area above should address the following seven items (answer not applicable if appropriate):

1. Public Law(s) or authorization related to this issue/issue area:
   P.L. 94-437, 1976.

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:

Staff continues to review and analyze the many changes in this complex legislation. Any new legislation introduced in the next Congressional session will also need to be reviewed and analyzed for impact on the Department's programs.

3. OPDIV/STAFFDIV activities to date on this issue/issue area:
   The Department requested review of and comment on the proposed reauthorization of the IHCIA as submitted to Congress and the Administration for consideration by the National 437 Steering Committee. OPDIV/STAFFDIVs provided initial review and comment by April 2000. Department staff met on June 27 to discuss initial comments. A subsequent subgroup met in June to further discussions on Title IV provisions. On July 27, 2000 the Assistant Secretary for Management and Budget testified in support of this proposed reauthorization but expressed concerns regarded changes to programs outside of IHS impacted by this legislation (i.e., Medicaid, Medicare and SCHIP).

4. Appropriations information related to the issue/issue area (FY00, FY01):
   The IHCIA has been funded through FY 01.

5. Obstacles to addressing issue/issue area:
   The complex nature of mandatory programs versus discretionary programs makes it difficult to address some changes, particularly in Title IV of the proposed legislation. These programs come under the jurisdiction of other authorizing Committees (i.e., the House Commerce Committee, House Committee on Ways and Means and the Senate Finance Committee).

6. Strategies to overcome obstacles:
   This legislation was introduced by Tribes through the National 437 Steering Committee. Their strategy was to provide the Administration and the Congress with their proposed legislative changes. This proposal was introduced in the House as H.R.3397 on November 16, 1999 and in the Senate as S.2526 on May 9, 2000. The Senate Committee on Indian Affairs (SCIA) reported S.2526 out of Committee on September 27, 2000.

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
   Deborah Drayer, ASL, 202/690-7450.

SECTION VI: INFRASTRUCTURE

#1		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Deterioration of water and sewer infrastructure.	• Provide assistance to repair (maintenance, repair of water and sewer systems). • Provide training on self-repairs. • Joint efforts to address impact of contaminated land from waste water, weed sprays and fertilizers.	IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: IHS funds projects to upgrade service to existing homes. Projects to upgrade existing community facilities are funded based on each IHS Area's priority system. The projects are scored on the priority system based on health risk, capital cost, deficiency level, tribal priority and etc. IHS will continue to provide tribes with operation and maintenance training and assistance in the development of operation and maintenance organizations.

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: In FY 1999, approximately 11,279 homes received upgraded service. In FY 2000 approximately $45 million was budgeted to provide first and upgraded service to existing homes. Also, since the program's earliest days, the IHS has assisted tribes by establishing and equipping operation and maintenance organizations. Additionally, IHS staff and contract trainers have provided extensive training, training funds and technical assistance to tribal/native utility operators and organizations.

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: The IHS plans to upgrade service to 9,300 previously served homes in FY 2000 and 9,660 previously served homes in FY 2001.
Each year's budget continues to include $900,000 for training tribal operation and maintenance organizations. This funding is provided to tribes to pay for operation and maintenance training, including the development of training programs.

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: Deteriorated water and sewer infrastructure that presents a risk to public health should be identified in the IHS sanitation facilities priority system.

6. **Strategies to overcome obstacles:**
IHS RESPONSE: IHS will continue to update the sanitation facilities priority system annually and consult with tribes on their sanitation facilities needs and priorities.

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: E. Crispin Kinney Acting Chief, Environmental Engineering Branch, Division of Facilities and Environmental Engineering. Office of Public Health, Indian Health Service (301) 443-1046

SECTION VII: DATA/REASEARCH

#1		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Data systems should not be based strictly on need to bill for health care service.	Make community specific health care data available.	All OPDIVs/STAFFDIVs

1. Public Law(s) or authorization related to this issue/issue area:

IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis. P.L. 94-437, "The Indian Health Care Improvement Act," as amended, Section 602, "Automated Management Information System," established an automated management information system for the Indian Health Service (IHS), which included a financial management system, a patient care information system, a patient privacy component, and a services-based cost accounting component.

ACF RESPONSE: In most ACF programs, health care costs are not authorized except where they are an integral part of the program such as Head Start. (See issue #1). ACF does not collect information on the health care needs of or health care services for Indians, including data for billing for health care services. Part 1304.20 (a)(1)(i) requires HS/EHS programs to establish procedures to track the provision of health care services.

AOA RESPONSE: Under Title VI, Tribes are required to conduct needs assessments. These assessments may include health data.

HCFA RESPONSE: Section 1903(a)(3) of the Social Security Act provides Federal matching payments to States for the design, development, or installation of mechanized claims processing and information retrieval systems as the HHS Secretary determines are likely to provide more efficient, economical and effective administration of States' Medicaid programs. These systems are required to be compatible with claims processing and information retrieval systems utilized in the administration of the Medicare program.

AHRQ RESPONSE: N/A

CDC RESPONSE: Public Health Service Act, particularly Title III, General Powers and Duties of the Public Health Service; 25 USC 18, Subchapter II, Section 1621m

HRSA RESPONSE: Secretary's Policy on the Collection of Race and Ethnic Data.

IGA RESPONSE: N/A

SAMHSA RESPONSE: N/A

FDA RESPONSE: N/A

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:

IHS RESPONSE: Since P.L. 94-437 was passed in 1976, the IHS has strived to provide an automated management information system for the IHS and its tribal and urban partners. The system has evolved into today's IHS Resource and Patient Management System (RPMS), a system that collects both clinical and administrative data. Information is generated at the local levels and forwarded to the Area who in turn sends it to the IHS National Data Repository in Albuquerque where it is aggregated for national purposes. The aggregated data is used primarily for statistical analysis and reporting to Congress. Billing is also conducted at the national level, but it is not the sole purpose of data collection. The Tribal recommendation to make community specific health care data available has been addressed; the capability is already there. The Division of Information Resources (DIR), Office of Management Support (OMS), IHS, relates the problem to possibly the lack of staff to extract data and insufficient training at the local levels. Consumers may not be aware of the reports they are capable of generating locally.

Actions to address this issue that the DIR's Information Technology Support Center in Albuquerque has implemented include a series of RPMS Training and a national Help Desk, both of which are available to local customers. The IHS has also made information available through the National Data Repository, the Internet, and epidemiology centers. Tribes have been very active in the area of community specific health care data. The innovative Tribal Epi Center program was authorized and four Centers were funded in FY 1996. Some of the four Centers have developed innovative strategies to monitor the health status of tribes and use sophisticated record linkage computer software to correct existing state data sets for racial misclassification. Equally important, these Centers provide immediate data feedback for self-governance tribal health programs to plan and decide the most efficient and effective health care services for their people.

ACF RESPONSE: Not Applicable

AOA RESPONSE: AoA, through the National Resource Center on American Indian Elders at the University of North Dakota, has developed a computerized needs assessment tool for the Tribes to use at their discretion. If they wish, they can submit the completed needs assessment forms to the National Resource Center for analysis. Tribal results are provided to the Tribe for their use in program planning.

HCFA RESPONSE: HCFA and IHS have established a joint IHS/HCFA Steering Committee to address key issues of mutual concern. The Steering Committee will be requested to establish a data subcommittee, which could address this concern.

AHRQ RESPONSE: N/A

CDC RESPONSE: Working with IHS, assist tribal governments in developing health data systems that will have practical public health applications, such as improved surveillance; In an effort to make community specific health care data available, CDC's National Center for Health Statistics (NCHS) has proposed the development of 2 new surveys:
Defined Population Health and Nutrition Examination Surveys (DP-HANES): The goal of the proposed DP-HANES data collection system is to provide flexible and timely access to high-quality examination and laboratory data for a range of defined populations that can not be addressed using the standard NHANES framework. Most of the sub-populations most suited to this system are not sufficiently large and/or sufficiently geographically dispersed to allow efficient data collection using a national sampling frame. State and Local Area Integrated Telephone Survey (SLAITS): Tracking/monitoring questions already exist on NCHS' National Health Interview Survey (NHIS), which assesses health status, health insurance, access to care, and health risk factors and behaviors. NCHS has developed and tested a program for efficiently obtaining State-level data with advanced telephone survey techniques, called SLAITS, which would build on the existing NHIS data and allow state-level comparisons with national data.

HRSA RESPONSE: OMH/OS is currently finalizing the Joint Report of the HHS Data Council Working Group on Racial and Ethnic Data and the Data Work Group of the HHS Initiative to Eliminate Racial and Ethnic Disparities in Health.

IGA RESPONSE: The IGA has established an Inter-Agency Tribal Consultation Workgroup to implement and institutionalize the Department's Consultation Policy. Because all OPDIVS are represented in this workgroup, it could be charged to address this recommendation.

SAMHSA RESPONSE: CSAP's feasibility study will be expanded to include data from at least one additional reservation/urban area site. Data will be compared from the previous collection effort to compare and contrast the two studies. This effort is also expected to yield a trainer's manual for technical assistance in expanding this effort across future sites, both within urban and reservation contexts. CSAP will obtain final findings from the American Indian Cultural Core Measures and will follow up as appropriate.

FDA RESPONSE: N/A

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: The RPMS originally began as the IHS Health Information System, was later expanded into the Patient Care Information System, and has evolved into the RPMS as described in #2 above.

ACF RESPONSE: The Head Start Bureau has, developed a software program (HSFIS) -- Head Start Family Information System – that grantees can use for record keeping and tracking.

AOA RESPONSE: See #2 above.

HCFA RESPONSE: HCFA and IHS, as well as advocacy representatives of States and Tribes, have performed analyses and are being solicited to provide information on data needs related to the health of AI/ANs.

AHRQ RESPONSE: AHRQ has discussed incorporating IHS data into HCUP—the Healthcare Cost and Utilization Project, a Federal-State-Industry partnership to build a standardized, multi-state, longitudinal data system. Presently, HCUP includes inpatient data and is managed by AHRQ. However, most States do not allow the source of data to be identified at the hospital level and, consequently, data could not be developed which is community specific. AHRQ has also discussed doing an oversampling of Indians in the MEPS—the Medical Expenditure Panel Survey--with the Indian Health Service in order to be able to produce data for American Indians and Alaska Natives. MEPS is a nationally representative survey of health care use, expenditures, sources of payment, and insurance coverage for the U.S. civilian noninstitutionalized population, as well as a national survey of nursing homes and their residents. MEPS is co-sponsored by the Agency for Health Care Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS). The type of oversampling discussed would produce national, not community-specific, data and would be very costly.

CDC RESPONSE:

- Periodically, publish MMWR articles addressing public health issues of importance to AI/AN communities;
- Provided technical assistance in the form of public health training needs assessments to a southwestern tribal health department;
- A successful pilot study of SLAITS was conducted in two states, producing State-level estimates on public and private health insurance coverage, access to and utilization of medical care, health status and limitation of activities. A second pilot study was conducted in another two states using a questionnaire on child well-being related to welfare reform. SLAITS is being used in 2000 to conduct a survey of children with special health care needs in each state and D.C.

HRSA RESPONSE: A draft report has been developed and circulated for review by HHS Agencies. Recommendations are wide-ranging and fall into areas such as diabetes, cardiovascular disease, immunizations, vital records, linguistically appropriate services, quality improvement, and risk factor data.

SAMHSA RESPONSE: In FY 1999, CSAP funded a feasibility study for $150,000 which represents a first step in the development of local infrastructure necessary to collect data in AI/AN communities. This data, which was collected in two American Indian communities, will give tribes a more accurate snapshot - if still somewhat limited - of the incidence and prevalence of substance abuse-related violence, especially domestic violence. American Indian Cultural Core Measures - Because tribes need data in order to obtain Federal funding, CSAP is engaged in the task of developing culturally appropriate measures for substance abuse prevention problems and efficacy in their unique prevention programs. Through the Cultural Core Measures Initiative, an expert at the University of Denver is working with other Indian measurement experts to revise the Core Measures for American Indians. Preliminary findings were presented to CSAP in February 2000.

FDA RESPONSE: N/A

4. Appropriations information related to the issue/issue area (FY00, FY01):

IHS RESPONSE: The DIR's activities are supported by the IHS general appropriation. Two million was appropriated in the FY 00 budget to improve health data systems, and $7million is included in the President's budget for FY 2001 to expand and supplement IHS and Tribal Epidemiology Centers.

ACF RESPONSE: N/A

AOA RESPONSE: N/A

HCFA RESPONSE: N/A

AHRQ RESPONSE: N/A

CDC RESPONSE: Joint funding of IHS-sponsored Tribal Epidemiology Centers proposed in FY 2002 budget initiative; Funding has not been provided in either the FY 2000 or 2001 budgets to fund DP-HANES or the use of SLAITS more broadly;

HRSA RESPONSE: N/A

SAMHSA RESPONSE: CSAP's feasibility study - FY 2000 - $150,000 CSAP's American Indian Cultural Core Measures - FY 2000 - $25,000

FDA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: Lack of training and adequate staff to perform information resource functions at the local levels and high turnover are obstacles to making community specific health care data available at the local level.

ACF RESPONSE: Not all HS tribal grantees have access to computers or staff skilled to use the technology.

AOA RESPONSE: N/A

HCFA RESPONSE: HCFA has little or no AI/AN specific data; additionally, there are confidentiality and privacy concerns, which limit the use of person specific data. Finally, Tribes are frequently reluctant to self-report information to entities outside of the Tribe.

AHRQ RESPONSE: See #3 above.

CDC RESPONSE:

- Lack of accurate data, particularly surveillance data;
- Limited AI/AN-targeted funds;
- Greater recognition is needed of the importance of baseline data on specific populations in order to understand differences in their health status and health care needs that are often masked when combined with larger population groups or geographic areas. Baseline data and continued monitoring are also essential in tracking the effectiveness of public health programs. Along with recognition of the importance of data must come sufficient funds to support the infrastructure needed for data collection;

HRSA RESPONSE: N/A

SAMHSA RESPONSE: Data collected is often not culturally appropriate to American Indian communities.

FDA RESPONSE: N/A

6. **Strategies to overcome obstacles:**
IHS RESPONSE: Strategies to overcome these obstacles are two-fold. First, the DIR's Information Technology Support Center in Albuquerque has implemented a series of RPMS Training and a national Help Desk, both of which are available to local customers. The IHS is also making information available from the National Data Repository, the Internet, and epidemiology centers. Secondly, to strengthen and support the progress by the Tribal Epi Centers.

ACF RESPONSE: Annual supplemental funding has been available to grantees to support the acquisition of hardware, software and training for staff. However, this additional funding is not a mandate and is only available on a contingency basis from year to year.

AOA RESPONSE: N/A

HCFA RESPONSE: Refer to #2.

AHRQ RESPONSE: See #3 above.

CDC RESPONSE: Work with tribal governments, state health departments, CSTE, and other federal agencies to improve health surveillance efforts directed toward AI/AN communities; It is crucial to raise awareness of the importance of community specific data as the foundation for decision-making relevant to public health policy and development of prevention and intervention programs.

HRSA RESPONSE: N/A

SAMHSA RESPONSE: Undertake studies to improve the cultural aspects of measurement and data collection. Use of American Indian researchers and data collectors.

FDA RESPONSE: N/A

7. **OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):**
IHS RESPONSE: Richard M. Church, Pharm.D., Director, Division of Information Resources, Office of Management Support, Indian Health Service, 5600 Fishers Lane, Room 5A-21, Rockville, Maryland 20857, Telephone: 301-443-0750

ACF RESPONSE: Dr. Helen Scheirbeck, Chief, American Indian Programs Branch/HSB; (202) 205-8437

AOA RESPONSE: Yvonne Jackson, Director, OAIANNHP, (202) 619-2713

HCFA RESPONSE: Wanetah Pinder (HCFA) – (410) 786-5493 NOTE: This issue will be addressed over a long term period.

AHRQ RESPONSE: Wendy Perry, Senior Program Analyst 301-594-7248

CDC RESPONSE: Ralph T. Bryan, MD, Senior CDC/ATSDR Tribal Liaison, Office of the Associate Director for Minority Health, Office of the Director, CDC, 505-248-4226
Dean S. Seneca, MPH, Minority Health AI/AN Program Specialist, Office of the Associate Director for Minority Health, Office of the Director, CDC
404-639-7210

HRSA RESPONSE: Dr. Bradford Perry, Public Health Analyst, Office of Minority Health, 301-443-0946.

SAMHSA RESPONSE: Steve Sawmelle Intergovernmental Coordinator , Office of Policy and Program Coordination, (301) 443-041

FDA RESPONSE: N/A

SECTION VII: DATA / RESEARCH

#2		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
	Establish a national database of pharmaceutical companies that have assistance programs (i.e., anti-rejection medication following kidney transplant).	FDA HCFA IHS

1. **Public Law(s) or authorization related to this issue/issue area:**
IHS RESPONSE: The Snyder Act (25 U.S.C.) provides basic authority for most health care services provided by the Federal Government to American Indians/Alaska Natives. The Indian Health Care Improvement Act, The Indian Sanitation Facilities

Act, and the Indian Self-Determination and Education Assistance Act also supply authority. Funds are made available through annual appropriations bills on a discretionary, non-entitlement basis.

HCFA RESPONSE: Section 1927 of the Social Security Act governs Medicaid coverage of outpatient drugs, but there is no Medicaid authority that governs drug coverage of individuals not eligible for Medicaid.

FDA RESPONSE: N/A

2. **Proposed OPDIV/STAFFDIV actions to address this issue/issues area:**
IHS RESPONSE: A national database of patient assistance for prescription drugs has been established by the Pharmaceutical Research and Manufacturers of America. A complete directory of pharmaceutical companies offering these services can be found on the internet at www.phrma.org/patients. This website has instructions for applying for assistance, information on what drugs are covered, and information on basic eligibility requirements. This information is accessible to all tribes, however if further assistance is necessary, the agency will help in any way possible. Generally, the patient's physician must request assistance and all eligibility requirements must be met on a patient-by-patient basis.

HCFA RESPONSE: Furnish source lists of pharmaceutical companies having drug assistance programs as well as other sources of information to IHS and tribal facilities. A current source list is also attached to this document.

FDA RESPONSE: N/A

3. **OPDIV/STAFFDIV activities to date on this issue/issue area:**
IHS RESPONSE: Area staff, local service unit staff, and tribal staff have worked with various pharmaceutical manufacturers to provide patient assistance. This assistance usually has taken place on an individual patient basis as the need has arisen. In some cases, area contract health offices have been of assistance, however, most of the information and arrangements must be made by the patient's physician and the patient. The agency will certainly provide needed assistance.

HCFA RESPONSE: This source list has been furnished to all previous requesters.

FDA RESPONSE: N/A

4. **Appropriations information related to the issue/issue area (FY00, FY01):**
IHS RESPONSE: NA
HCFA RESPONSE: N/A

FDA RESPONSE: N/A

5. **Obstacles to addressing issue/issue area:**
IHS RESPONSE: Despite the change from Federal deficits to Federal surpluses the budget caps established by the Balanced Budget Act of 1997 remain in affect through FY 2002. The FY 2001 budget allocation provided for the House Interior Appropriations Subcommittee was $302 million below the FY 2000 level and $1.7 billion less than the amount requested by the Administration. While the Senate Interior Subcommittee has received a budget allocation that is greater than the House's, it is still significantly below the President's request. The President has proposed discretionary spending limits at levels necessary to serve the American people, including American Indians/Alaska Natives. The Administration has consistently reminded Congress that the allocation to the Interior Subcommittees is insufficient to make the necessary investments in Indian programs.

HCFA RESPONSE: N/A

FDA RESPONSE: N/A

6. **Strategies to overcome obstacles:**
IHS RESPONSE: The Indian Health Service needs to continue to present the health care needs of Indian people in such a way that our budget is a top priority whenever funding allocation decisions are made. This will include consulting with tribal representatives, and working with staff from HHS, OMB and the Appropriations Committees, to ensure that the information needed to make the most compelling possible case is presented in a timely manner.

HCFA RESPONSE: N/A

FDA RESPONSE: N/A

7. OPDIV/STAFFDIV contact on this issue/issue area (name, title, telephone number):
IHS RESPONSE: Samuel M. Hope, R.Ph., M.S., Chief Pharmacist, Oklahoma City, Oklahoma, (405) 951-3829

HCFA RESPONSE: Cindy Pelter (HCFA) – (410) 786-1176

FDA RESPONSE: N/A

SECTION VII: DATA/RESEARCH

Issue # 3		
Issue/Issue Area	Tribal Recommendation	OPDIV/STAFFDIV Assigned
Community-Based Research	a) "All research should go through the local tribal Institutional Review Board. Research should always have the involvement of tribes. Using universities as the focal point for research within Indian communities creates negative partnering with tribes." b) "There is considerable interest in the amount of funding from NIH available for Indian research. For example, if the 1.5% set aside was applied to NIH's $18 billion budget, tribes could have access to $250 million in research and planning funds. Currently tribes compete with universities and large institutions, how can the federal government assure that tribes are competitive with these groups?"	AHRQ CDC NIH SAMHSA

1. Public Law(s) or authorization related to this issue/issue area:
AHRQ Response: N/A

CDC Response: CDC derives its authority primarily from the Public Health Service Act (42 U.S.C. §§ 241, 242(l), 242(n), 242(o), 243, 249, 252, and 254) which allows the CDC to prevent the spread of disease, promote the quality of life, monitor chronic disease, and to prevent illness, injury, and disability.

NIH Response: N/A
SAMHSA Response: 42 USC 290aa; and 42 USC 290ff

2. Proposed OPDIV/STAFFDIV actions to address this issue/issues area:

AHRQ Response: AHRQ will continue to seek ways to help build research infrastructure among Indian populations as a step in helping tribes and Indians run their own research endeavors.

CDC Response: CDC strives to both work directly with tribal research partners, as well as to forge partnerships between CDC-based, tribal, and academic research collaborators.

NIH Response: The type of research supported by the NIH traditionally requires a university environment or setting because of the types of technology and other types of resources that are required. For example basic research aimed at increasing understanding the biological or genetic basis of disease and/or clinical studies looking at potential new therapies or understanding the progression of disease must be based in technological centers which are often university or hospital based. However, recognizing that participation at all levels is necessary in reducing and eliminating health disparities, the NIH is committed to designing programs that will provide opportunities for TCU-community partnerships to become engaged in implementing

preventive strategies and in the translation of new knowledge from the bench to the bedside. Toward that end, one of the components in the proposed Center for Research on Minority Health and Health Disparities is the Office for Community Based Research and Outreach.

SAMHSA Response: While activities under SAMHSA's Knowledge Development and Application (KD&A) grant program (see below, "activities to date") are primarily health research and evaluation studies and not strictly direct research, such grants are community based and are, in most instances, available to tribes and tribal organizations. Some of the KD&A activities are tribally targeted. SAMHSA will continue to facilitate the inclusion of AI/AN populations in the KD&A program by ensuring that notification of grant opportunities are sent to tribal and urban organizations in order to provide adequate opportunity and time for the development of fundable proposals. It is up to the individual tribal entities to direct such applications through the local tribal Institutional Review Boards. Many of SAMHSA's KD&A grant opportunities do not require university affiliation, but grant applications must be appropriately structured and show sufficient rigor to compete against other applicants. SAMHSA will continue to conduct regional and national workshops to encourage, assist, and enhance the capabilities of tribes and tribal organizations to respond to these community-level grant opportunities.

An example of a tribally targeted KD&A activity being conducted by SAMHSA is the Circles of Care program. SAMHSA's Center for Mental Health Services (CMHS) will continue to provide grants under this program and will continue to require tribal and urban Indian grantees to go to their communities to define wellness and the proper incorporation of traditional healing into conventional treatment. The National Center for American Indian and Alaska Native Mental Health Research at the University of Colorado will continue to provide the cross-site evaluation for the program and will require the plans to be approved by local tribal Institutional Review Boards.

3. OPDIV/STAFFDIV activities to date on this issue/issue area:

AHRQ Response: AHRQ agrees that research should go through the local tribal Institutional Review Board and that research should always have the involvement of tribes. In fact, tribes should be integrally involved in the development and implementation of research and not be tag-alongs to universities or other research institutions. To help tribes compete for funding, AHRQ recognizes the need to help build research capacity among Indian populations. To that end, AHRQ has many training programs that Indians may utilize (see the AHRQ website). Also, AHRQ is conducting seminars around the country on using data from AHRQ's Medical Expenditure Panel Survey (MEPS). In addition, a major program grant was recently awarded to an Indian-based consortium to perform research on health care disparities among the Indian elderly; part of this effort is capacity building. Also, AHRQ, with funding from the Indian Health Service, recently awarded a planning grant to an Indian-focused primary care practice-based research network , which will perform, and build capacity to perform, primary care based research.

CDC Response: In addition to its own Institutional Review Board (IRB) for review of human subjects' research, the CDC cooperates closely with both tribal and IHS-based human subjects review boards, and has assisted at least one tribe in the development of its own IRB.. Some CDC assignees to the IHS are active members if the IHS National IRB. Further, CDC actively seeks tribal partnerships in its research activities involving AI/AN participants.

NIH Response: To date the major action taken to address the dearth of NIH sponsored community based health research has been the planned establishment of the Office of Community Based Research and Outreach in the proposed Center. The Office will develop and implement State and local research programs related to health disparities and minority health and encourage partnerships among State and local departments of health, academic centers and institutions, and community-based organizations. The Office is also charged with developing and implementing a community-based research program that focuses on disease prevention, implementing health messages in relevant racial and ethnic minority and disadvantaged communities, and elucidating barriers to effective health care. In addition, the Office will coordinate with appropriate DHHS agencies and other Federal entities on programs of relevance to the mission of the Center. The ORMH is currently recruiting for the director of the Community Based Research and Outreach Program.

We believe that the new programs in the above referenced office will be key in increasing tribal involvement in Indian health research. As indicated previously, however, grant awards from the NIH depends on a competitive process. One of the priorities of the proposed Center will the development of a process for leveling the playing field for the purpose of increasing access to NIH funds.

SAMHSA Response: The primary source of SAMHSA's discretionary funds is the Knowledge Development and Application program. The goal of this program is to develop new knowledge about ways to improve the prevention and treatment of substance abuse and mental illness, and to work with State, local and tribal governments as well as providers, families, and consumers to apply that knowledge effectively in everyday practice. The competitive grant activities under the KD&A program target services, for example, to women, adolescents, methamphetamine or inhalant abusers, and those with or at-risk for HIV, and the activities are often directed to new or innovative approaches for providing culturally relevant services.

Under CMHS' tribally targeted Circles of Care program, nine tribal and urban Indian communities have completed two of three years in their projects to improve the system of care with a special emphasis on cultural issues, as defined by the communities. Most are doing focus groups to assess the current system and define cultural issues in the communities. All have worked with local tribal Institutional Review Boards.

Another example of an AI/AN-targeted KD&A program is the American Indian/Alaska Native (AI/AN) Youth Priority Initiative. All three of SAMHSA's Centers are participants in the initiative. One of the grantees is Feather River Tribal Health, Inc. in California, which is conducting two activities: "Bear Dreamers," a substance abuse prevention project focusing on children ages 8-12 and their families, and "Na Nom Pem," a substance abuse treatment project focusing on adolescents' aftercare from inpatient treatment, and/or in the justice system.

4. Appropriations information related to the issue/issue area (FY00, FY01):

AHRQ Response: In FY00 several research grants were made that focus on the health of Indians and have tribal involvement. A large program project grant was awarded to the University of Colorado (Manson) to research health care disparities among Indian elderly. Another large grant was made to the University of New Mexico (McCabe) to look at diabetes care among the Navajo. A planning grant, funded by the Indian Health Service (IHS) was awarded to a primary-care based research network to develop a plan for developing/strengthening a network of office-based primary care practices dedicated to research.

CDC Response: N/A; no funds appropriated for these activities.

NIH Response: As indicated earlier, if established legislatively in the current Congressional session, the projected budget for the Center in FY01 will be $100 million plus $97 million, the existing appropriations for minority health research and training, for a total of $197 million. This represents the pool of NIH funds to which Native Americans together with ethnic and racial minorities will have much improved access through relevant and culturally appropriate program development efforts by the NIH. Should the Center be established administratively, its budget in FY01 will be $97M, the existing appropriation for minority health research and training

SAMHSA Response:
Circles of Care (for AI/AN)
FY 00 - $2.4 million
FY 00 - $2.4 million

Feather River Tribal Health, Inc.
FY 00 - $537,000

Other examples are two of the programs discussed under matrix item #5:
Practice/Research Collaboratives
FY00 - $3.1 million ($650,000 for AI/AN)
FY01 - $2.7 million ($400,000 for AI/AN)

Exemplary Practices for Adolescents
FY00 - $4.3 million ($430,000 for AI/AN)
FY01 - $2.2 million ($430,000 for AI/AN)

5. **Obstacles to addressing issue/issue area:**

AHRQ Response: It is difficult finding conduits for building research infrastructure among Indian populations. Presently, it appears that few tribes have the necessary research expertise to take the lead in developing and carrying out research projects and to compete successfully for grant funding.

CDC Response: Limited number of tribally-based IRBs.

NIH Response: The only known obstacle at the current time to legislatively establishing the Center is the agenda in the House. Given the time remaining in the current session of the Congress, it is unlikely that the legislation that establishes the Center will be address in the House during the current session.

SAMHSA Response: The research community requires the use of evidence based approaches to treatment and the use of standardized instruments which are not "normed" for special populations, particularly for American Indian and Alaska Native communities. Some tribal grantees participating in SAMHSA grants have expressed objection to what they see as the cultural insensitivity of the instruments, which they say reflect white middle class values and focus on problems rather than strengths. Further, the tribal communities often verbalize a history of exploitation by researchers, including intrusion into their ceremonies.

6. **Strategies to overcome obstacles:**

AHRQ Response: AHRQ will encourage grant applicants to ensure that they have adequate and "real" tribal involvement in any proposed research projects–AHRQ review committees will consider this in their reviews. AHRQ will continue to explore the role that Tribal Colleges and Universities might play in this effort. AHRQ will continue to look for opportunities for supporting the development of research infrastructure in Indian country.

CDC Response: Continue to foster increased understanding among CDC staff regarding special circumstances, cultural sensitivities, and other important issues that are unique to working with tribal research partners. Continue to recruit/train AI/AN researchers.

NIH Response: There are no methods available to the NIH for impacting the activities of the Congress.

SAMHSA Response: Demonstrate respect for the diversity of tribal cultures, and the right of each tribal community leadership to define its research priorities. Encourage collaboration with tribal colleges and universities in grant activities.

7. **OPDIV/STAFFDIV contact on this issue/issue area(name, title, telephone number):**

AHRQ Response: Wendy Perry, Senior Program Analyst, 301-594-7248

CDC Response: Ralph T. Bryan, M.D., Senior CDC/ATSDR Tribal Liaison, Office of The Associate Director for Minority Health, Centers for Disease Control and Prevention, c/o IHS Epi Program, 5300 Homestead Rd. NE, Albuquerque, NM 87110, Tel: 505-248 4226, FAX: 505 248-4393, e-mail: rrb2@cdc.gov; and Staff Liaison:Dean Seneca, Minority Health Specialist Office of the Associate Director for Minority Health, Centers for Disease Control and Prevention MS-D39, 1600 Clifton Rd. NE, Atlanta, GA 30333, Tel: 404-639-7220, FAX: 404-639-7039 e-mail: zkg8@cdc.gov

NIH Response: John Ruffin, Ph.D., Director, Associate Director for Research on Minority Health and Director, Office of Research on Minority Health. Phone: (301) 402-1366.

SAMHSA Response: Steve Sawmelle, Intergovernmental Coordinator, Office of Policy and Program Coordination, (301) 443-0419

SECTION VIII: CONCERNS FOR OTHER DEPARTMENTS - The following Issues/Issue Area and Tribal Recommendations were also voiced during the five tribal listening council meetings. These concerns are outside of the HHS' purview, however, the Office of the Secretary, IGA, will refer these tribal concerns to the appropriate Departments for their information:

Tribal Concerns Outside of HHS' Purview		
Issue/Issue Area	Tribal Recommendation(s)	OPDIVs/STAFFDIVs Assigned Response
Tribes need to work better with OMB on the budget process. Develop intergovernmental agreements with the local health facilities and state governments to develop procedures for the disposal of chemical waste from the local health facilities. States are not engaging in meaningful consultation with tribes. Tribes do not have the infrastructure that counties and states have had for some time.	Formalize a consultation process with OMB. Need for review by state and federal agencies of legislation that violates Indian treaty obligations.	

Program Name	P.L. Number	Type of Grant	FY 2000 Enacted Appropriation	Allocation Information
Title IV-B, subpart 1, Child Welfare Services	Social Security Act, as amended	Discretionary, Formula	291,955,289	Based on Grant application, population and income-based formula
Title IV-B, subpart 2, Promoting Safe and Stable Families	Social Security Act, as amended	Mandatory, Formula	295,000,000	1% Set-aside
Temporary Assistance for Needy Families	104-193	Mandatory, Preappropriated, Formula	16,488,667,000	Based on Tribe/State data
Child Support Enforcement (program to be implemented in FY 2001)	Social Security Act, as amended	Mandatory	3,210,800,000	Policy Pending
Low Income Home Energy Assistance	103-252	Discretionary, Formula	1,100,000,000	Based on Tribe/State data about eligible population
Community Services Block Grant	103-252	Discretionary Block Grant	527,644,497	Based on Tribe/State data on eligible population
Child Care and Development Block Grant	105-33	Discretionary Block Grant	1,172,672,000	2% Set-aside
Child Care Mandatory and Matching Funds of the Child Care and Development Fund	104-193	Mandatory, Formula	2,313,743,000	2% Set-aside
Head Start	100-297	Discretionary, Formula	5,266,446,017	13% for Tribes, Migrants and Disability services -- $147 milli allocated to tribes in FY00 anc $175 million estimated for FY(
Family Violence Prevention and Services/Grants for Battered Women's Shelters -- Grants to States and Indian Tribes	104-235	Discretionary, Formula	101,107,364	10% Set-aside
Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless, and Street Youth	106-71	Discretionary	14,997,422	
Transitional Living for Homeless Youth	106-71	Discretionary	20,500,843	
Abandoned Infants	104-235	Formula	12,205,716	
Runaway and Homeless Youth	106-71	Discretionary	43,647,409	
Native American Programs	93-644; most recent amend. 105-361	Discretionary	35,416,275	
Developmental Disabilities Projects of National Significance	104-183	Discretionary	10,242,923	

Social Services Research and Demonstration	Social Security Act,	Discretionary	27,488,108

APPENDIX 8

ACRONYMS

ACF:	Administration for Children and Families
AHRQ:	Agency for Health Care Research and Quality
AI/AN:	American Indians/Alaska Natives
ANA:	Administration for Native Americans
AOA:	Administration on Aging
ASMB:	Assistant Secretary for Management and Budget
BIA:	Bureau of Indian Affairs
CDC:	Centers for Disease Control and Prevention
CHEF:	Catastrophic Health Emergency Fund
CHR:	Community Health Representatives
CHS:	Contract Health Services
CSAP:	Center for Substance Abuse Prevention
CSC:	Contract Support Cost
CSTE:	Council of State and Territorial Epidemiologists
DIR:	Division of Information Resource
DP-HNES:	Defined Population Health and Nutrition Examination Survey
DSH:	Disproportionate Share Hospital Payments
EMS:	Emergency Medical Services
EPA:	Environmental Protection Agency
Epi Centers:	Epidemiology Centers
ESRD:	End stage renal disease
FDA:	Food and Drug Administration
FQHC:	Federally Qualified Health Centers
FY:	Fiscal Year
HCFA:	Health Care Financing Administration
HCUP:	Health Cost and Utilization Project
HHS:	Department of Health and Human Services
HRSA:	Health Resources and Services Administration
IGA:	Office of Intergovernmental Affairs
IHCIA:	Indian Health Care Improvement Act (P.L. 94-437)
IHS:	Indian Health Service
IRB:	Institutional Research Boards
ISDEA:	Indian Self-Determination and Education Assistance Act (P.L. 93-638)
JCAHCO:	Joint Commission for the Accreditation of Health Care Organizations
LNF:	Level of Need Funded
MEPS:	Medical Expenditure Panel Survey

NCHS:	National Center for Health Statistics
NHIS:	National Health Interview Survey
NIH:	National Institutes of Health
OCSE:	Office of Child Support Enforcement
OMB:	Office of Management and Budget
OPHS:	Office of Public Health and Science
P.L.:	Public Law
RFP:	Request for Proposals
RPMS:	Resource and Patient Management System
RYTC:	Regional Youth Treatment Center
SAMHSA:	Substance Abuse and Mental Health Services Administration
SLAITS:	State and Local Area Integrated Telephone Survey
TANF:	Temporary Assistance for Needy Families
USET:	United South and Eastern Tribes

HHS Definition of Consultation is:

"Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process which results in effective collaboration and informed decision making."